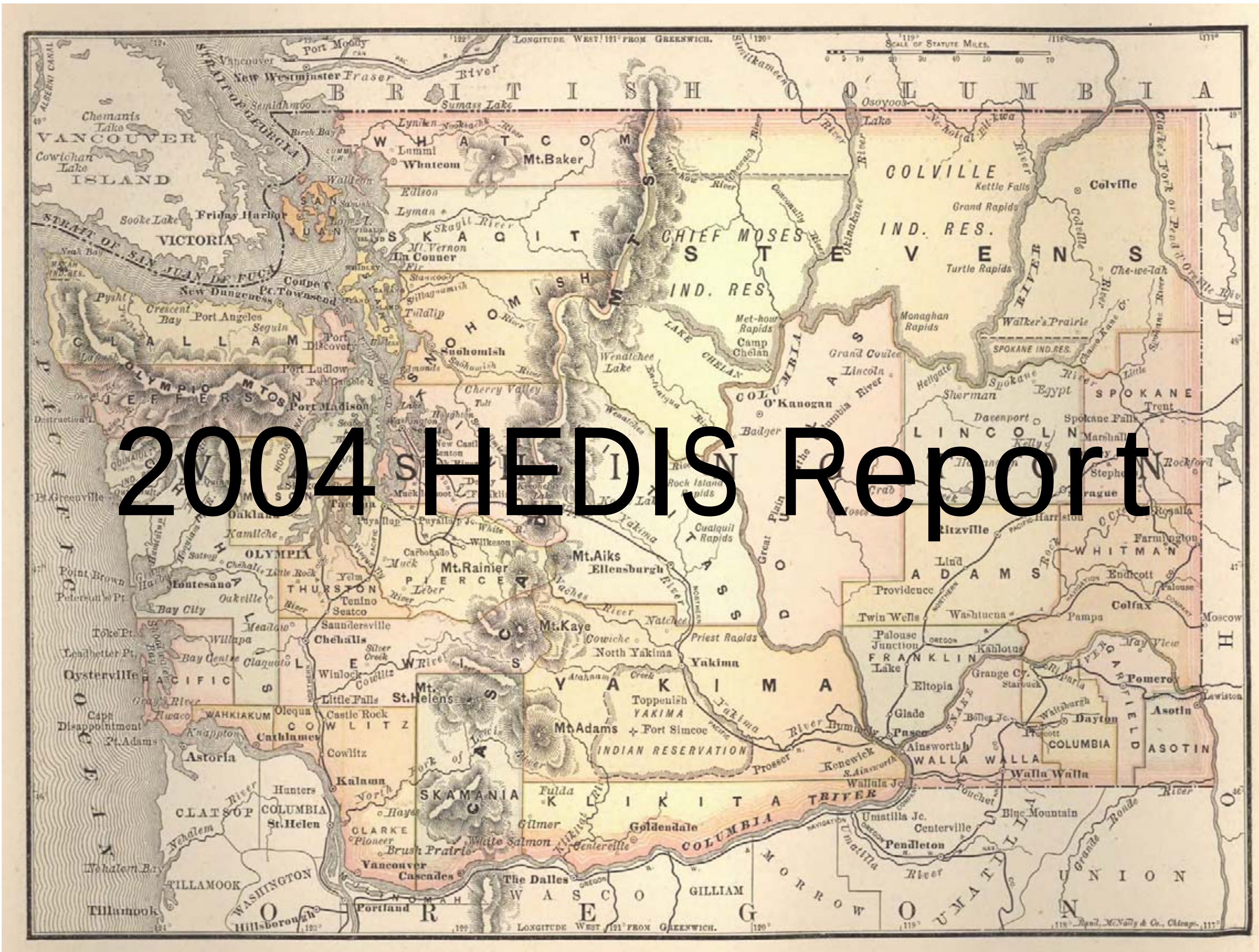
State of Washington

1888 Washington State Historical Map



2004 HEDIS Report

Healthcare Improvement and Measurement Section
Division of Medical Management
Medical Assistance Administration

MESSAGE FROM THE DIRECTORS

The year 2004 marks publication of the seventh annual Washington State HEDIS Report. This report presents health plan performance in 2003 on rates of health care screening tests, primary care provider visits, and other indicators of quality of care.

HEDIS performance measures are valid, standard quality measures. Improving preventive care measures can improve the health of the population in Washington State by keeping people healthy. Over time, dollars spent keeping people well rather than on treating preventable illnesses is good use of public funds.

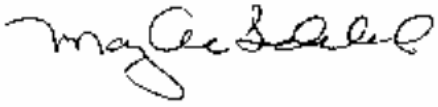
Washington State health plans improved the majority of rates this year—many significantly—and statewide average rates in prenatal care, postpartum care, and all childhood immunizations except chicken pox are above the national Medicaid averages reported by the National Committee for Quality Assurance.

Public reporting of quality measures is designed to help improve the quality of health care. The federal government is moving toward a single comprehensive set of validated quality measures that can be reported and used by all stake holders in the nation's health care system.

We have an opportunity to use the science of quality improvement, and make real progress in providing the highest quality medical care. Measuring performance allows us to identify areas needing improvement. Many health plans have impressive quality improvement programs, which can support doctors who want to improve care. Measuring performance also allows us to inform consumer choice, and to use the measures as quality incentives, which can foster accountability and help reduce the disparities in health care quality.

To attain the mission and vision of the Medical Assistance Administration (MAA), we need to continue to measure performance. We need to provide the environment and public policy that supports health care providers. We also need to use data and information to promote strategies that spend dollars to achieve consistent levels of high quality care.

We remain fully committed to continuing our partnership with stakeholders in improving the health care for all residents in Washington State.



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Printed by the Washington State Department of Printing

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Additional information on Washington State,
DSHS, and the Medical Assistance Administration is also available on that website

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EXECUTIVE SUMMARY

This is the seventh annual Washington State HEDIS report. Each year the Medical Assistance Administration (MAA) and the Health Care Authority (HCA) select a small number of HEDIS measures that are relevant to the populations served from among fifty-two measures. Some measures are reported for both populations.

This year, health plans in Washington improved the majority of rates for most measures over the past year. Many were significant improvements. Across all health plans, a total of 78 individual rates improved or remained the same this year; 28 of those significantly improved. Variance among health plans continues to narrow.

National Medicaid averages, available this year, show Washington State above the national rates in prenatal care and postpartum care and all childhood immunizations except chicken pox.

Trends in most measures are encouraging. Over the time period measured, about half the individual rates are significantly improved. While chicken pox remains the lowest rate for all health plans, the statewide median is up 59 percentage points over a five-year period.

Several areas hold opportunities for improvement. Statewide averages show that less than 40 percent of children from birth to 15 months are getting all six of the recommended well child care visits. Just over half the children three to six years old are getting an annual visit, while only a third of the adolescents are getting the recommended annual visit. Only a few of the chronic care measures for asthma and diabetes are above the national Medicaid average. Postpartum care, which fell six percentage points this year, needs vigilance to ensure women get needed care after delivery.

To pursue perfection in health care and realize the vision of reducing disparities and meeting individual needs requires commitment and collaboration of the state, public and private sector providers, and community organizations.

I. INTRODUCTION

Pursuing Perfection in American health care….The secret is promising, without compromise, what we will do for each and every person who comes into our care, one at a time.

Donald Berwick, MD, President and CEO of the Institute for Healthcare Improvement, articulated this vision a few years ago, and advised that healthcare services can be targeted and can meet individual needs when "every patient is the only patient."

Health plans, health care providers, and state agencies can apply this vision to measuring and working together to improve health care services.

Since 1999, Washington State has published an annual report summarizing the performance of contracted managed health care plans on selected HEDIS[1] measures. Focused quality improvement projects implemented by health plans have resulted in measurable improvement in clinical performance rates. Each health plan's contribution is evident in the significant gains reported this year.

This seventh annual HEDIS report is intended to provide easy to read information for health plan executives and managers, state legislators, policy makers and program managers, health care consumers, and others interested in the health care services provided to enrollees of Washington's publicly funded managed health care programs. Readers who want more detail than is in the report this year or explanation of technical terms are encouraged to refer to the resources cited in this report, to earlier Washington State HEDIS reports,[2] and the *HEDIS 2004 Technical Specifications*, published by NCQA.

Content of this report

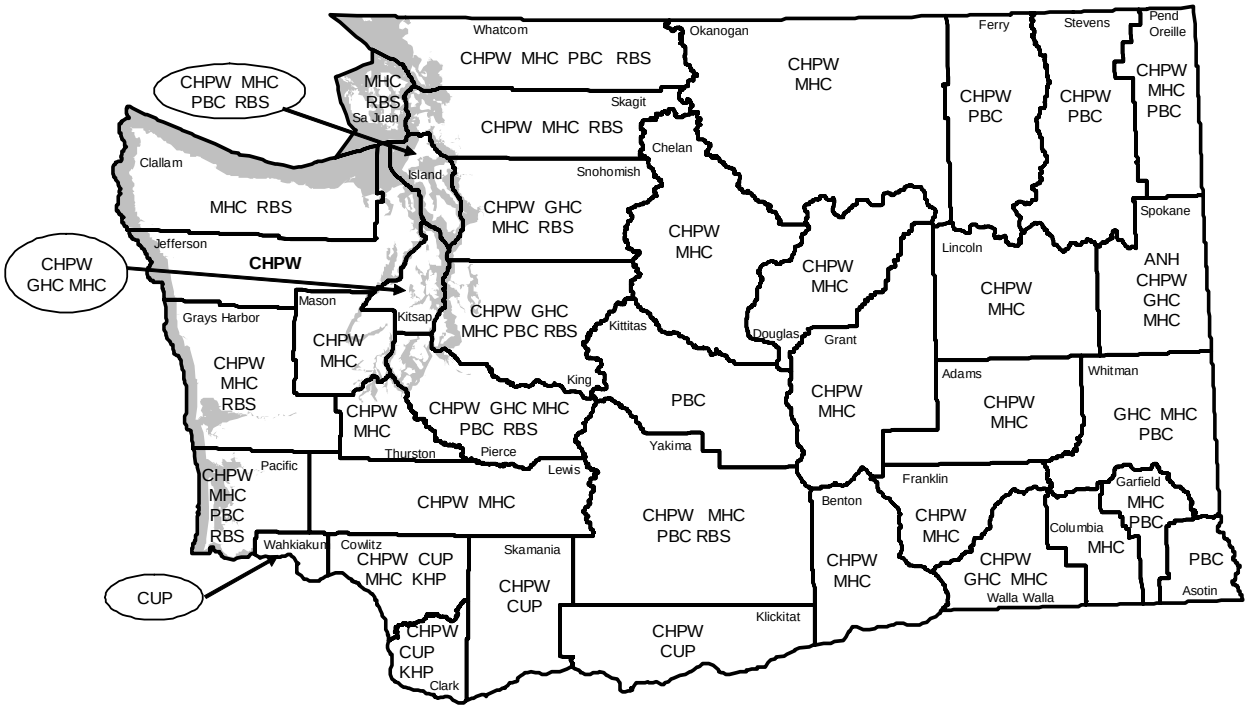
The 2004 HEDIS report presents state-contracted managed care plan HEDIS rates and statewide aggregate rates for services delivered in 2003, trends, and analysis of select HEDIS measures. HEDIS rates for the Medicaid and commercial populations are collected and reported separately.

Health Plan coverage. Washington is comprised of 39 counties. Seven health plans participate in from two to as many as thirty counties. In four rural counties, enrollment in managed care was voluntary because only one health plan participated in Healthy Options, the Medicaid managed care program. Figure 1 shows the health plans participating in state programs and the county the health plan served in 2003.

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] Copies of reports are available at http://MAA.dshs.wa.gov/newsdoc/HEDISreport.pdf or by calling 360-725-1618

Medicaid. The Medicaid program in Washington, administered by the Medical Assistance Administration (MAA), finances healthcare benefits for around 967,000 low-income residents—about one of every five residents. Approximately half of these are enrolled in the managed care program, including women who are pregnant, children enrolled in the State Children's Health Program (SCHIP), and Medicaid-eligible children of adults enrolled in Basic Health (BH).[3] The remaining fifty percent are in the fee-for-service program, including persons receiving Supplemental Security Income (SSI). For more information on Washington State Medicaid or managed care program, go to http://fortress.wa.gov/dshs/maa

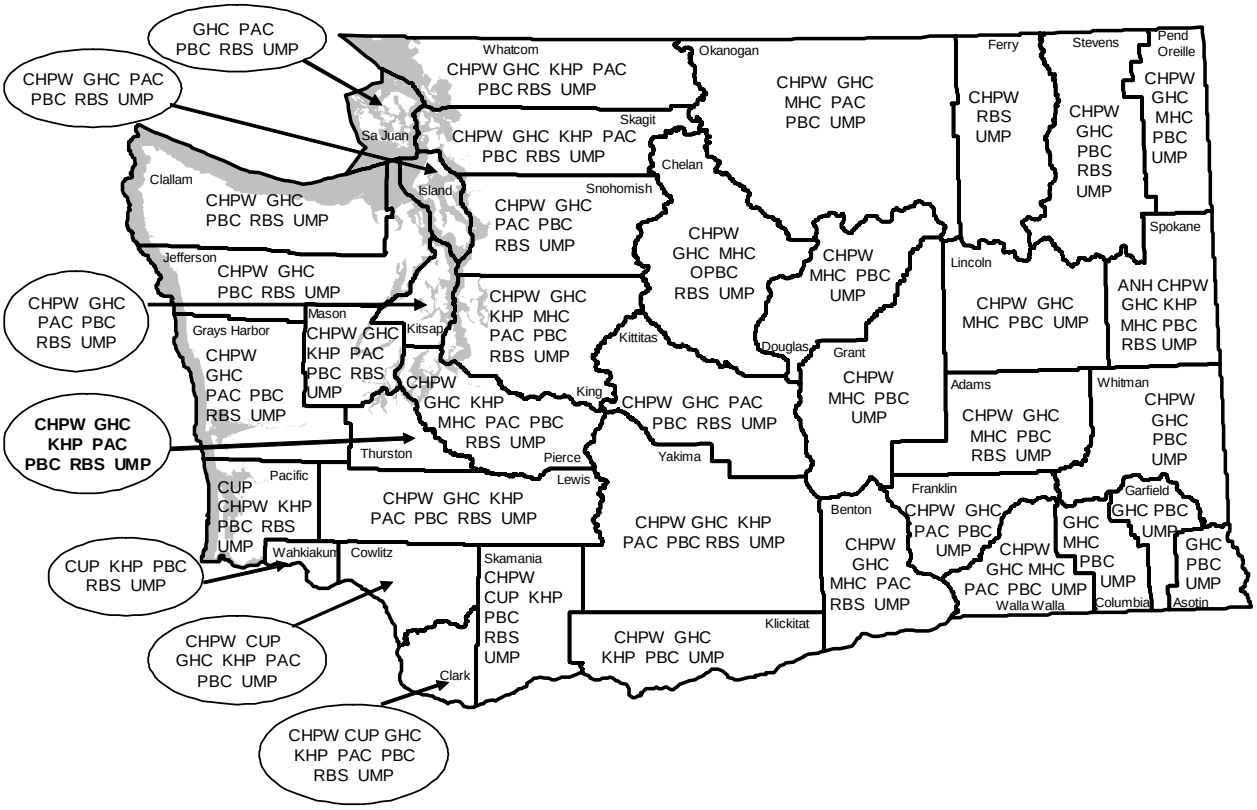
Figure 1 – Medicaid Service Areas 2003



Commercial. The Health Care Authority (HCA) contracts with managed care plans to provide health benefits for Washington State employees, retirees, dependents, and adults enrolled in the BH program. In 2003, there were 451,160 enrollees in these programs. About twenty-five percent (142,411) were in BH and the remaining 308,759 were in the public employees program. These groups are represented in the HEDIS commercial population. Further information on the HCA is available at www.access.wa.gov

[3] The state program for persons without insurance who have income above the limit established for Medicaid.

Figure 2 – Commercial Service Areas 2003



The HEDIS process

Purpose. HEDIS is a standard set of performance measures collected, reported, and audited by health plans nationwide. The primary goal of HEDIS is to provide valid and reliable measures of care and services to evaluate performance and highlight opportunities for targeted improvement. Recently, Washington and other states are using HEDIS rates as incentive opportunities for health plans to improve clinical performance.

Method. HEDIS specifications require a systematic sampling method to assure data integrity. For most measures, health plans choose from an administrative or hybrid method to calculate HEDIS rates (see glossary).

HEDIS is designed so that the hybrid method produces results with a sampling error of ±5 percent at a 95 percent confidence level (CI). Some health plan rates are based on relatively small populations and have a greater margin of error, or CI, associated with certain rates. The size of the sample should always be considered when making comparisons.

HEDIS requires that all eligible members be included when a measure applies to less than 100 members, and when a measure has fewer than 30 eligible members, that the rate not be publicly reported (shown as "NA").

Health plans report audited HEDIS rates, verified by an independent NCQA certified auditor as unbiased estimates through a

HEDIS Compliance Audit.™ The audit process is outlined in *HEDIS 2004 Compliance audit, Volume 5,* and at www.NCQA.org

With permission from NCQA, health plans use the NCQA web-based Data Submission Tool (DST) to submit auditor-secured HEDIS rates to the state on or before June 30th each year.

Performance rates. HEDIS rates are reported as percentages—the proportion of persons who receive a defined service and meet the eligibility specification, out of the health plan's total eligible population or random sample of the eligible population. Rates refer to services delivered in the calendar year prior to the report year.

Multiyear rates are shown when the reporting entity or measure specifications have not changed materially. Trends can show significant improvement in a health plan, even when rates are lower than other health plans.[4]

Analysis. Each health plan performance this year is examined relative to the health plan rate last year, to other health plans, the statewide and national averages, and to the health plan's performance over a four or five year period.[5] Percentages may be rounded to the nearest whole number and differ slightly from actual values.

Symbols denote health plan specific rates which are statistically significant[6] improvements from last year (↑); rates statistically significantly above (▲) or below (▼) the statewide average; and current rates that are statistically significantly above (↑↑) or below (↓↓) the health plan's rate in 2000 or 2001. Statistically significant differences are calculated at a .05 level using a two-tailed Z test.

Regional rates. The 2003 *State of Health Care Quality* report, published annually by NCQA, includes for the first time, same-year commercial and Medicaid results and national trends. The report represents about 71 million Americans, and shows significant regional differences across measures. The authors conclude that public reporting (i.e., accountability in medial practice) is the single largest determinant of variation in performance. The national rates are included in this report and offer a comparison of Washington rates with national rates.

County level Medicaid HEDIS Childhood Immunization rates, included in prior reports, are not included this year. MAA and the Department of Health (DOH) are working together to produce multi-year county level analysis of immunization rates based on HEDIS data. These data provide a broader level of analysis, where more than one health plan operates in a region and can be viewed along with other health statistics compiled by DOH, and county demographics, such as annual county health profiles published by the Washington Health Foundation (WHF), which focus on health disparities and access to primary care.[7]

[4] Health plan changes in data collection method from year to year can affect the rate, but these rates are not excluded from comparison ratings in this report.

[5] For measures where the statewide median was tracked, median rates are used to enable comparison across years.

[6] A statistically significant result is one that is unlikely to be due to chance.

[7] County health profiles are available at http://www.whf.org or by calling 206-285-6355.

II. THE MEDICAID POPULATION

Medicaid health plans face technical challenges in collecting HEDIS, such as turnover of members. MAA does not require health plans to collect all HEDIS measures every year, but select measures that are relevant to the Medicaid population. Not all measures collected are included in this report. The well child and adolescent care measures were eligible for rotation this year.[8]

The Medicaid report includes seven measures with 29 separate rates:

- Childhood Immunizations
- Prenatal and Postpartum Care
- Well Child Visits in the First 15 Month of Life
- Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Adolescent Well Care Visits
- Appropriate Medications for people with Asthma.
- Comprehensive Diabetes Care

Highlights

Significant improvements are shown in many measures. Key findings include:

- Across all health plans, a total of 78 individual rates improved or remained the same this year; 28 of those significantly improved including eight by CHPW and six by CUP
- About half the individual health plan rates significantly improved over a four or five-year period
- 48 individual health plan rates were significantly above the statewide average this year
- All health plans improved the Childhood Immunization Comb 1 rate this year except GHC, which fell slightly
- The Washington State average Childhood Immunization Comb 1 rate this year (65 percent) exceeds the Medicaid national average (62 percent); the median (67 percent) is up 11 percentage points from the rate last year (56 percent) and 14 percentage points over a five year period
- All health plans improved the Hepatitis B rate this year
- Although VZV remains the lowest Childhood Immunization rate for all health plans, CHPW gained 22 percentage points and CUP gained 11 percentage points this year and the statewide median rate increased over a five year period from 22 percent to 81 percent—an increase of 59 percentage points
- All health plans improved the 6 visit Well Child Visit rate except CHPW, which fell slightly, and CUP, which remained the same
- All health plans significantly improved the Prenatal Care rate over the five-year period

[8] Health plans may choose to report the same data two years in a row when NCQA rotation criteria are met.

- The Prenatal Care statewide median rate is 91 percent this year, up from 78 percent in 2000; the average this year (89 percent) is 12 percentage points above the national Medicaid average (77 percent) and nearly at the *Healthy People 2010* goal of 90 percent
- The Postpartum Care statewide median rate gained 12 percentage points in three years, but fell 6 percentage points this year

Childhood Immunizations

A recent study by a national non-profit organization, with support of the Centers for Disease Control, ranked 30 clinical preventive services based on health impact and cost effectiveness. Childhood immunization is the only preventive service to receive a maximum score of ten—the highest benefit and most cost-effective service.[9]

Although in the last 50 years, childhood immunizations have led to dramatic declines in many childhood diseases, more than forty percent of two-year-olds in the U.S. are still missing one or more recommended immunizations.

Preterm infants are at increased risk of vaccine preventable diseases (VPD) but are less likely to receive immunizations on time according to a recent study published in *Pediatrics*. The study also found that healthcare providers are largely unaware of the proper protocol for catching up on immunizations.[10]

The HEDIS Childhood Immunization measure is based on the immunization schedule recommended by the Advisory Committee on Immunization Practices (ACIP). The schedule includes up to twenty doses of vaccines for ten diseases by age two. The FDA recently approved a new combination vaccine that protects against DTaP, Hep B, and Polio for infants at 2, 4, and 6 months of age, which can replace nine separately administered injections.

The *Healthy People 2010* goal for full childhood immunization (ages 19 to 35 months) is 90 percent.

The HEDIS Childhood Immunization measure is a composite that calculates the proportion of children continuously enrolled in the health plan for twelve months prior to their second birthday who receive the following immunizations by their second birthday and by the time period specified:

4 DTaP (diphtheria-tetanus toxoid-acellular pertussis)
3 IPV (injectable poliomyelitis)
1 MMR (measles-mumps-rubella)
3 HiB (Haemophilus influenza type B meningitis)
3 Hep B (Hepatitis B)
1 VZV (Varicella or chicken pox)

HEDIS also calculates two combination rates. The Combination 1 (Comb 1) rate, which includes all the above immunizations except VZV, is included in this report.

[9] More information is available at www.thecommunityguide.org and www.prevent.org. The full text of "Guide to Clinical preventive Services, 2nd Edition" and the most recent recommendations published by Partnership for Prevention are available at www.ahrq.gov/clinic/uspstfix.htm

[10] A catch up schedule, approved by the ACIP is available at www.cdc.gov/nip/recs/child-schedule.htm#catchup or by calling the National Immunization information hotline at 1-800-232-2522 (English) or 1-800-232-0233 (Spanish).

Diphtheria, Tetanus, and Pertussis (DTaP). DTaP is a combined vaccine that protects against diphtheria, tetanus, and pertussis.

Diphtheria is a serious disease and up to 20 percent of persons with diphtheria die. Diphtheria causes obstructed breathing, abnormal heart rhythms, and inflammation of the nerves including those of the diaphragm.

Diphtheria is primarily spread when an infected person coughs or sneezes. Although fewer than five cases per year have been reported in the U.S. since 1980, diphtheria is endemic in more than 28 other countries and importation of diphtheria is a risk.

Tetanus (lockjaw) results when bacteria enters a wound; tetanus is not spread from person to person. Tetanus causes muscle spasms and stiffness initially of the face and neck and then generalized, with about a 30 percent fatality rate.

Tetanus Toxoid is a highly effective vaccine. About 40 cases of tetanus are reported each year in the U.S. Recently there is an increasing number of tetanus cases among injecting drug users.

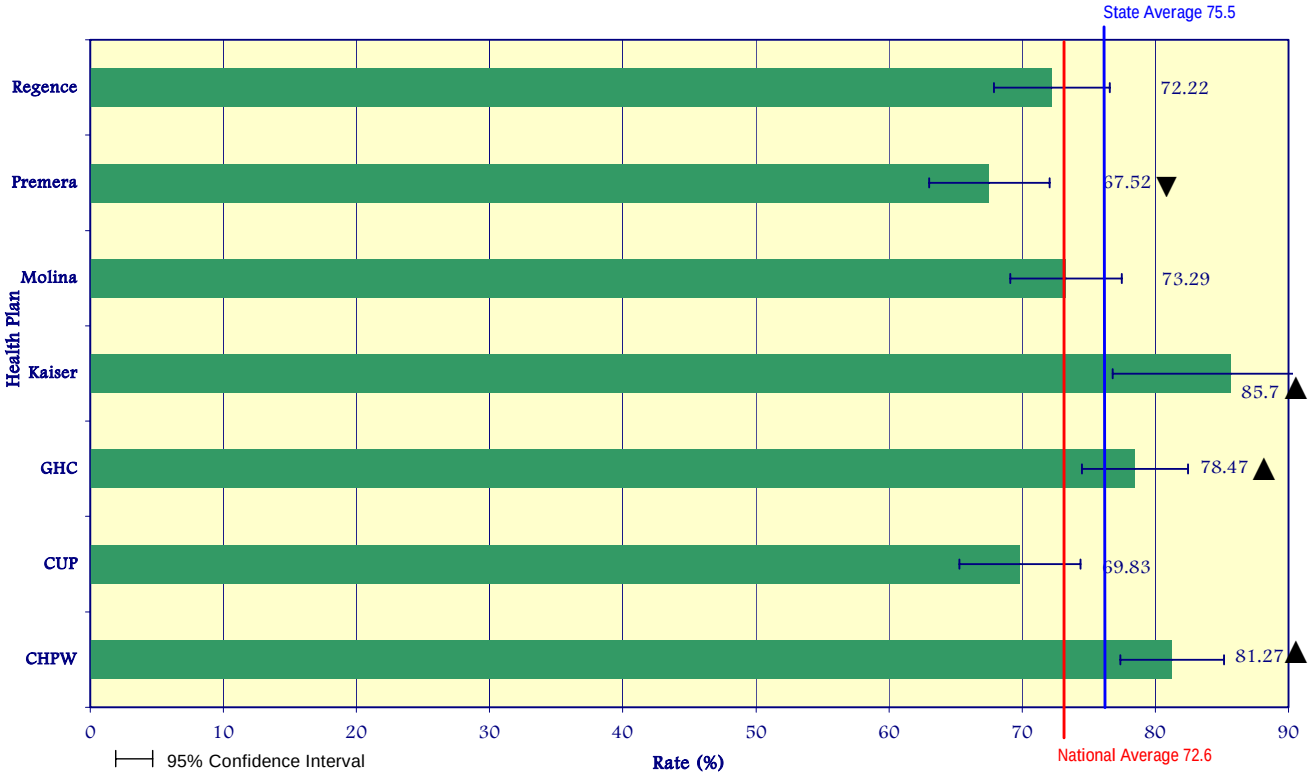
Pertussis (whooping cough) is a highly contagious disease involving the respiratory tract, spread primarily by infected people coughing or sneezing. The most common complication is pneumonia, which occurs in one out of twenty cases. Infants are most likely to suffer from seizures and brain damage, and account for 90 percent of deaths from pertussis. Waning immunity in adolescents and adults increases the chance that infants too young to have received all three doses of the vaccine will get pertussis. The vaccine is about 80 percent effective.

The number of pertussis cases is rising. In 2002, there were 9,771 cases reported nationwide—the largest number of cases since 1967. Approximately 100 to 500 cases of pertussis are reported annually in Washington.

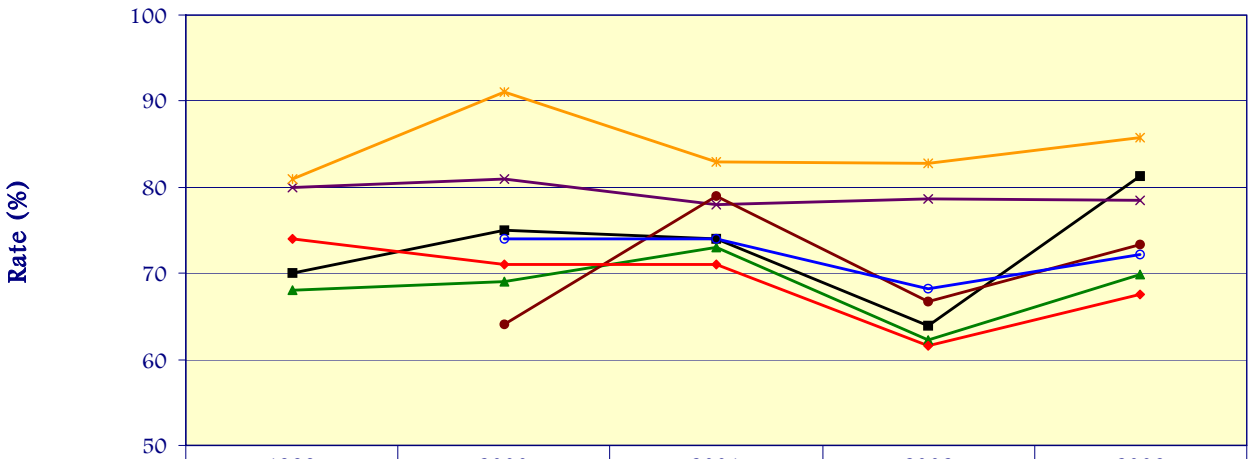
Nationwide the fourth dose of DTaP is not being given according to schedule. A Washington State project focused on improving the fourth DTaP was initiated in 2003 and includes development and distribution of educational materials through CHILDProfile[11] and schools.

[11] CHILDProfile is the Washington State immunization registry.

Medicaid Childhood Immunizations - DTaP



Medicaid Childhood Immunizations - DTaP



	1999	2000	2001	2002	2003	
CHPW	70	75	74	64	81 ↑	↑↑
CUP	68	69	73	62	70 ↑	
GHC	80	81	78	79	78	
Kaiser	81	91	83	83	86	
Molina		64	79	67	73 ↑	↑↑
Premera	74	71	71	62	68 ↑	↓↓
Regence		74	74	68	72	

Analysis

- All DTaP rates improved this year except GHC, which remains about the same.
- Both CUP and Molina improved the DTaP rate 7 percentage points this year
- Rates range from 81 percent (CHPW) to 68 percent (PBC)
- Over a 5-year period, 3 DTaP rates significantly improved and 3 dropped

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Measles, Mumps, and Rubella (MMR). MMR is a combined vaccine that protects against Measles, Mumps and Rubella.

Measles is caused by a virus, is highly transmissible, and is spread when an infected person coughs or sneezes. Complications include pneumonia, encephalitis, permanent deafness, mental retardation, and death.

Despite the availability of vaccine for forty years, measles remains the leading cause of vaccine preventable death in childhood. Death from measles in the U.S. occurs in about one of a thousand persons infected; children too young to be immunized account for half the reported deaths from measles. Measles is often imported from other countries, including adopted children (accounting for more than 20 percent of cases in the U.S.)[12]

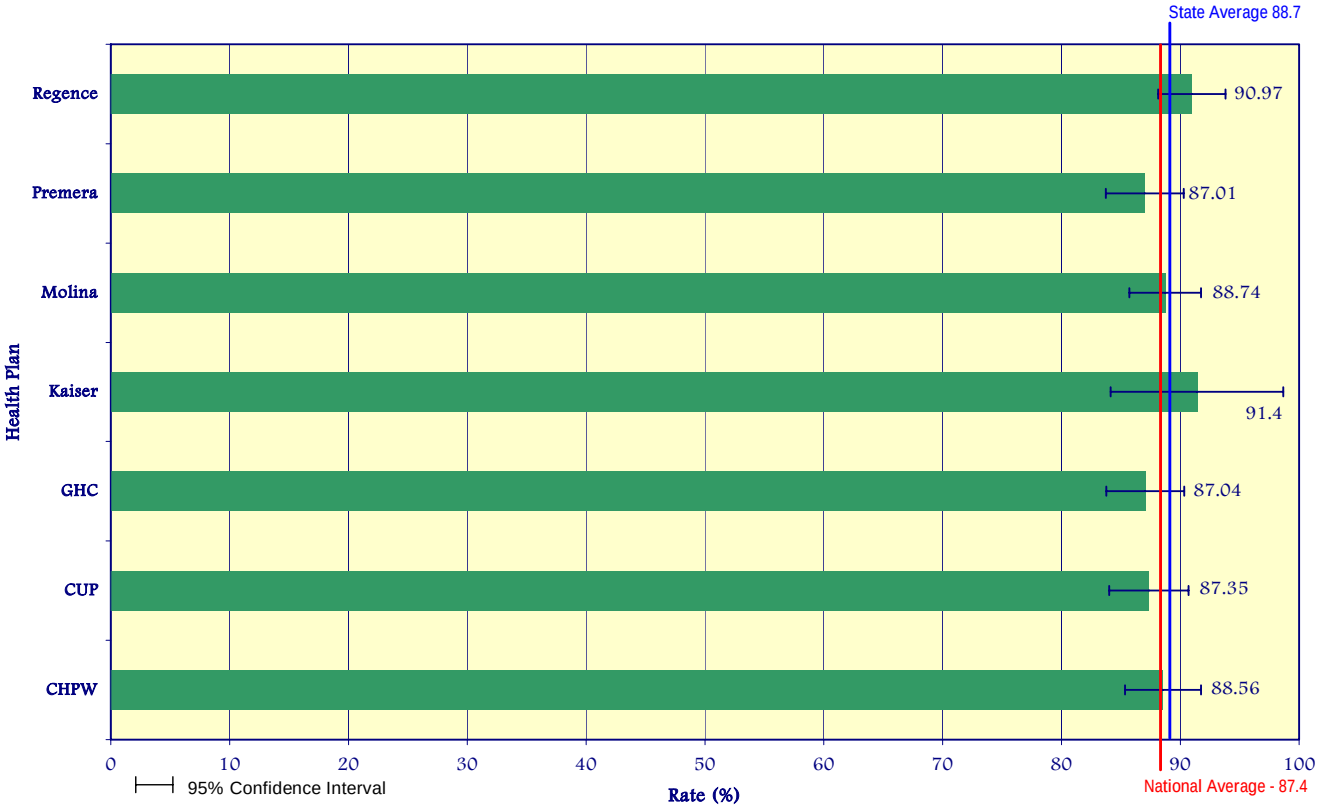
Mumps is caused by a virus of the lymph nodes, spread from person to person through the air, but is less contagious than measles. Adults usually have more complications than children.

Rubella is caused by a virus spread through the air and is moderately contagious. Although rubella is a mild disease, it causes birth defects in up to 85 percent of infants who are infected in the first trimester of pregnancy.

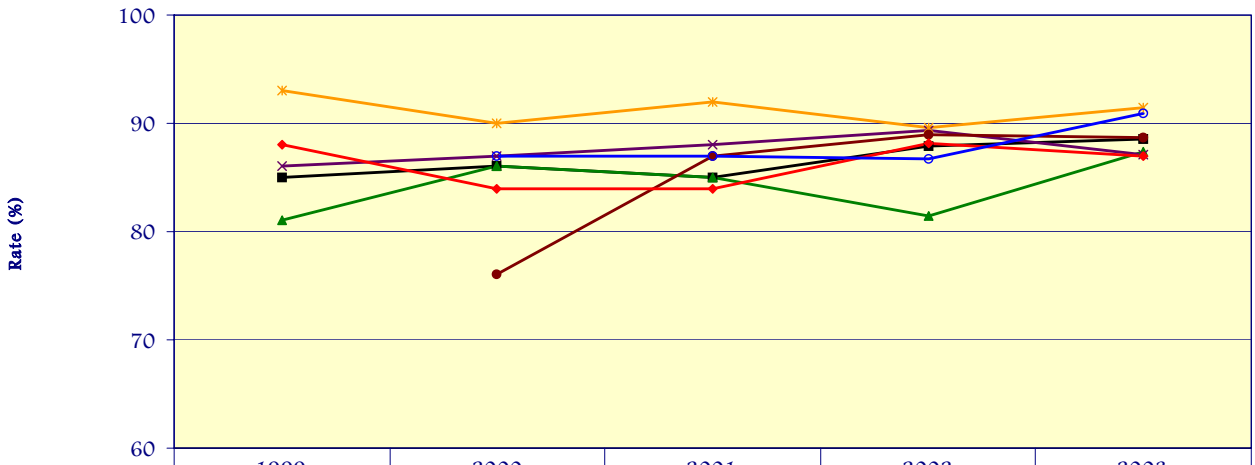
Outbreaks of rubella in the U.S. continue to occur in groups of individuals who are not immunized, e.g., immigrants and those who do not immunize for religious or philosophical reasons.

[12] MMWR 2004. 53 (14): 309-10.

Medicaid Childhood Immunization - MMR



Medicaid Childhood Immunizations - MMR

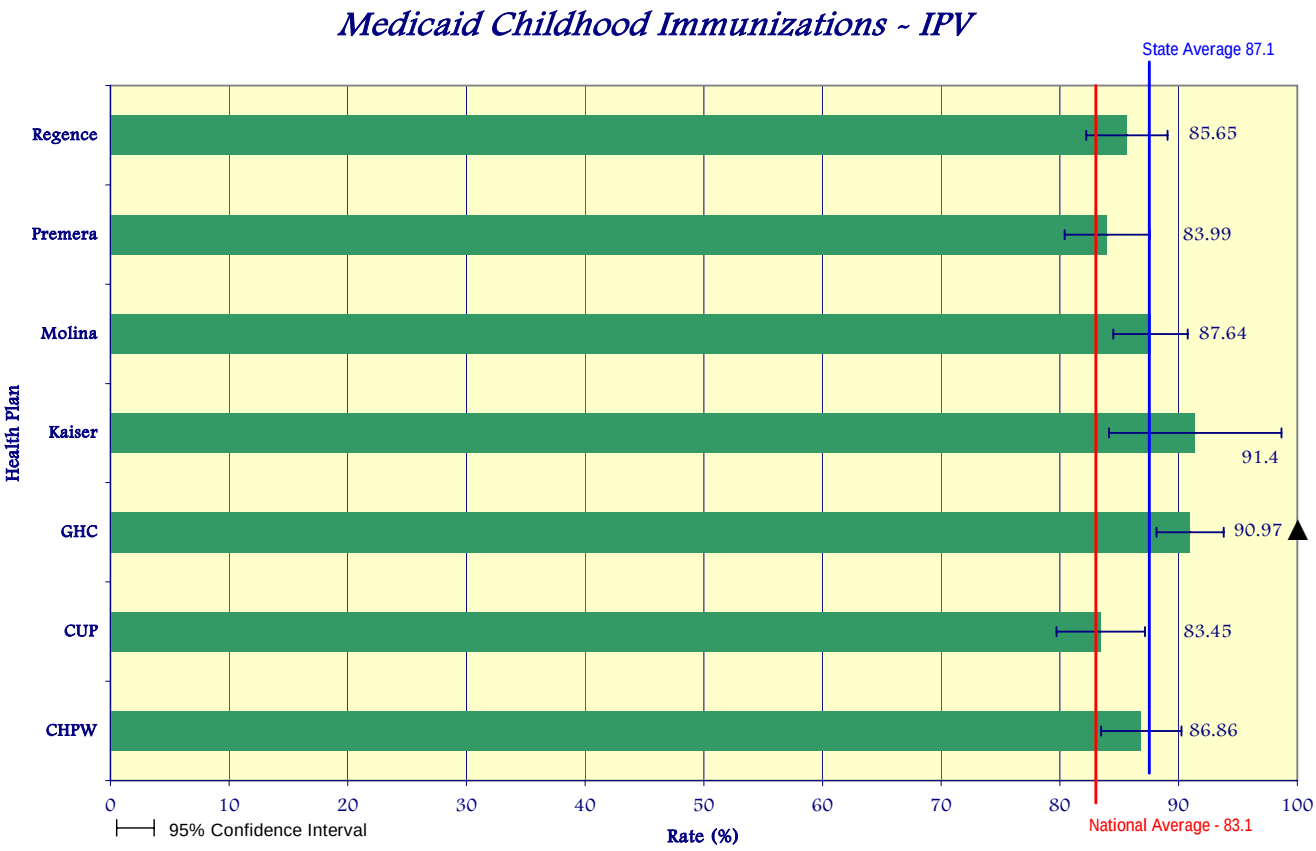


	1999	2000	2001	2002	2003	
CHPW	85	86	85	88	89	↑↑
CUP	81	86	85	82	87 ↑	↑↑
GHC	86	87	88	89	87	
Kaiser	93	90	92	90	91	
Molina		76	87	89	89	↑↑
Premera	88	84	84	88	87	
Regence		87	87	87	91 ↑	↑↑

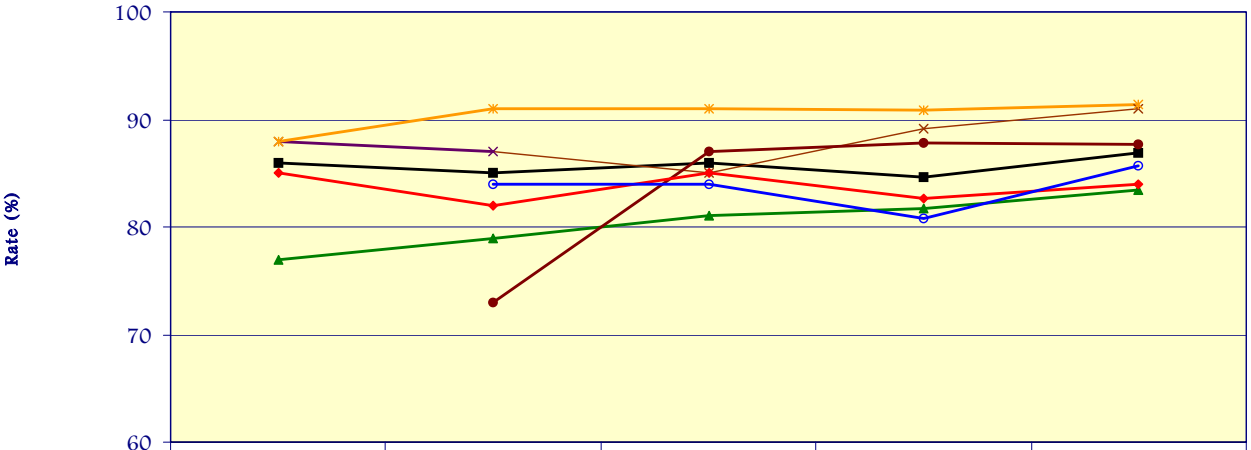
Analysis

- Four MMR rates improved this year
- Rates range from 91 percent (Kaiser) to 87 percent (Premera)
- All MMR rates improved over a 5-year period except Premera, which dropped slightly

Inactivated Polio Vaccine (IPV). Poliomyelitis is a virus spread via the fecal-oral route from contaminated hands or objects. About two percent of polio cases result in paralysis. The Salk vaccine, introduced 50 years ago reduced the number of paralytic cases in the U.S. from 2,525 cases in 1960 to none since 1979. Continued vaccination and surveillance are necessary because polio can be imported from countries where polio remains endemic.



Medicaid Childhood Immunizations - IPV



	1999	2000	2001	2002	2003	
CHPW	86	85	86	85	87	
CUP	77	79	81	82	83	↑↑
GHC	88	87	85	89	91	↑↑
Kaiser	88	91	91	91	91	
Molina		73	87	88	88	↑↑
Premera	85	82	85	83	84	
Regence		84	84	81	86 ↑	↑↑

Analysis

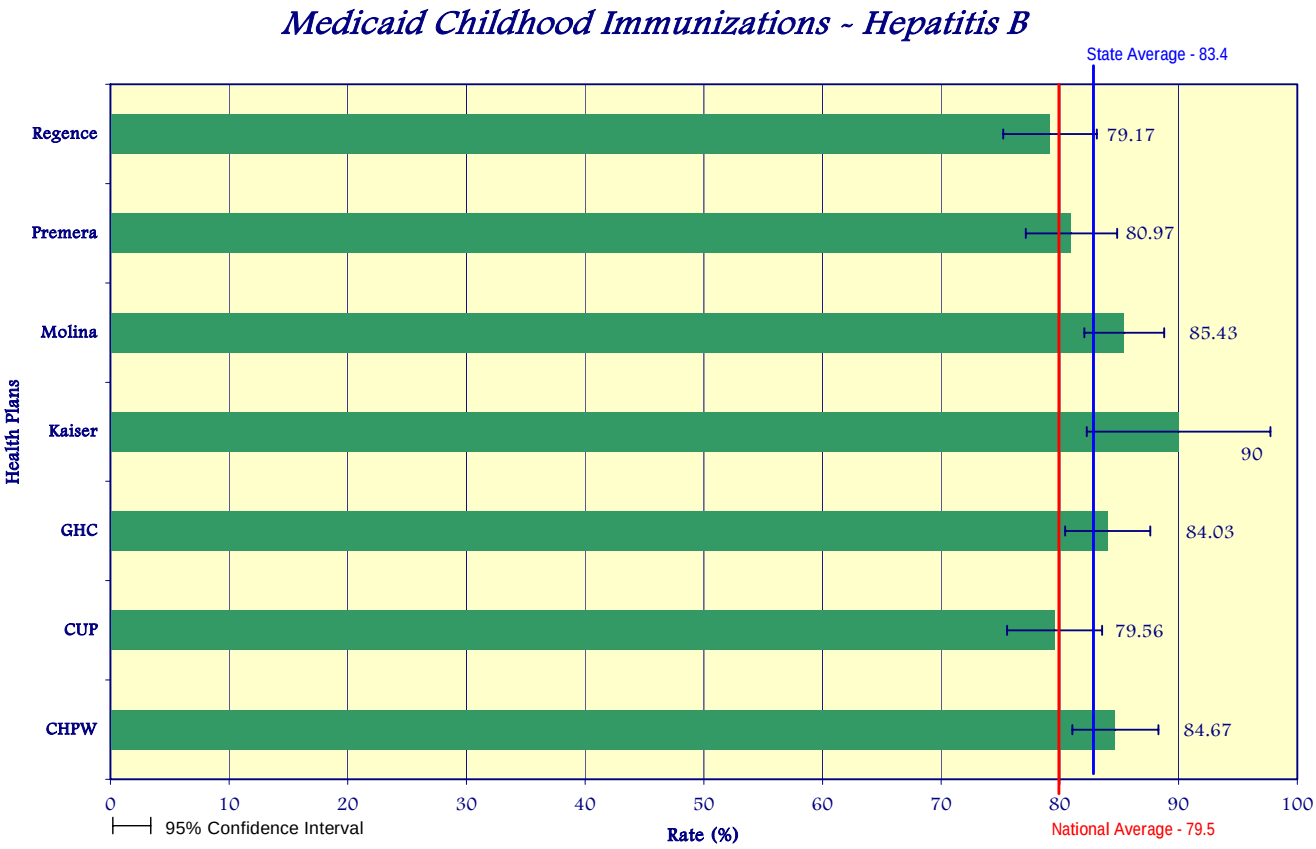
- Five IPV rates improved this year and one remained about the same
- All health plans improved significantly over a 5-year period except Premera, which is below the 1999 rate this year
- The range of rates is from 91 percent (Kaiser) to 83 percent (CUP)

Hepatitis B (Hep B). Hep B is a serious viral infection spread through a skin puncture or mucous membrane contact with blood or other body fluid, and can be transmitted via medical procedures, sharing personal items, and skin wounds, as well as sexual contact, injecting drug users, and from an infected mother to an infant during birth. Hep B becomes chronic in 90 percent of infants who contract the infection during childbirth.

Hep B is a reportable disease in Washington State, but many people are asymptomatic and undiagnosed.

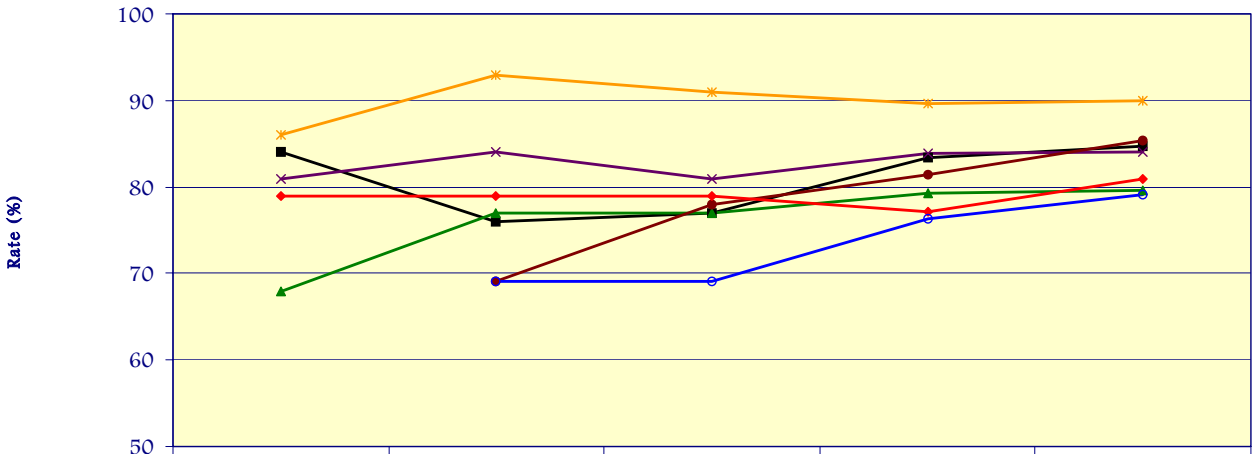
A three-dose vaccine series is highly effective. The ACIP recommends giving all infants the birth dose of Hep B before hospital discharge.

About five percent of the U.S. population has Hep B. Nationally, and in Washington State, disproportionately higher rates of Hep B are seen among people of lower socioeconomic status and among certain racial and ethnic groups, although the number of new cases has steadily declined since 1991 and racial disparities have narrowed.[13] This trend may be due to adoption of a comprehensive strategy of early prenatal screening, re-testing those at high risk late in pregnancy, treating the infant at birth, and adding Hepatitis B to the childhood pediatric vaccination schedule.



[13] Department of Health. *The Health of Washington State 2004 Supplement.* July 14, 2004. P2.

Medicaid Childhood Immunizations - Hep B



	1999	2000	2001	2002	2003	
CHPW	84	76	77	83	85	↑↑
CUP	68	77	77	79	80	↑↑
GHC	81	84	81	84	84	
Kaiser	86	93	91	90	90	
Molina		69	78	81	85 ↑	↑↑
Premera	79	79	79	77	81	
Regence		69	69	76	79	↑↑

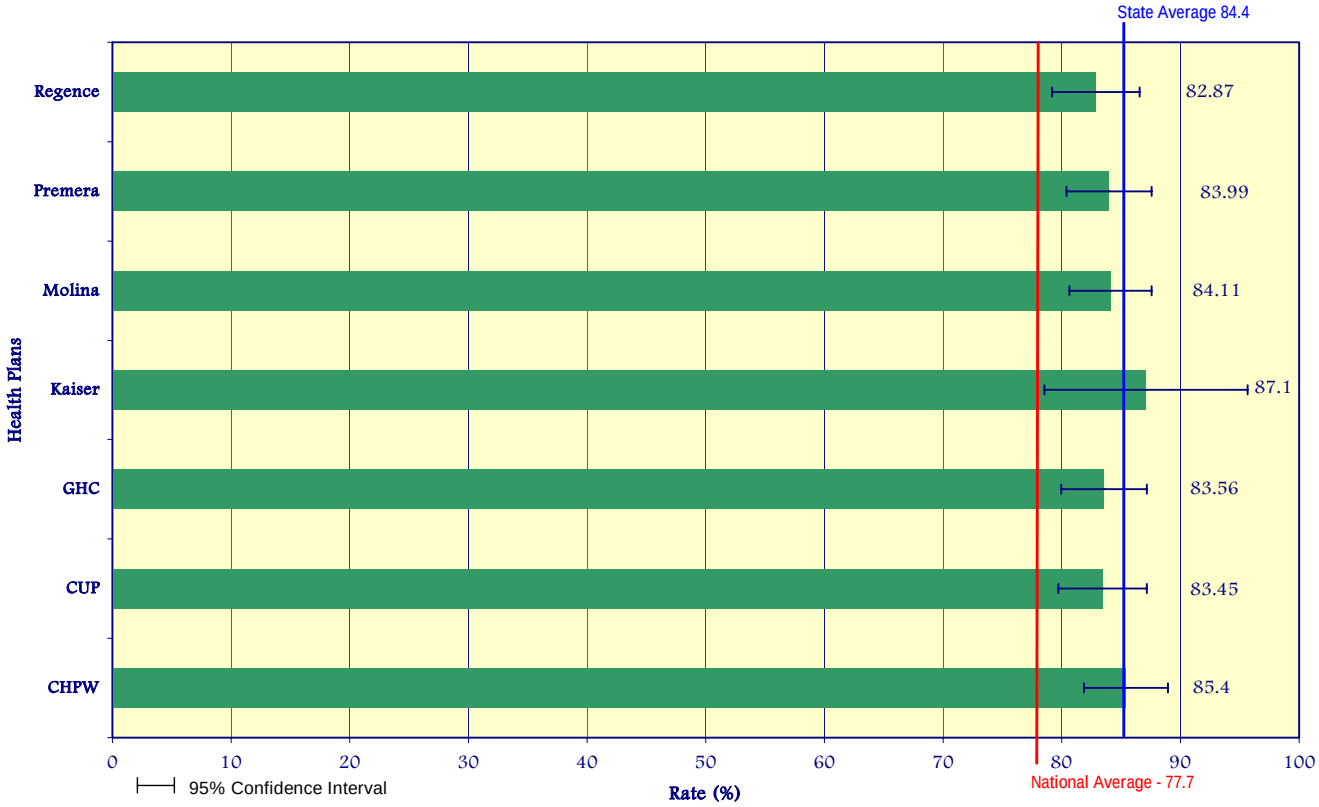
Analysis

- All health plans improved the Hep B rate both this year and over a 4 or 5-year period
- The range of rates is from 90 percent (Kaiser) to 79 percent (Regence)
- Over a 5-year period four health plans significantly improved the Hep B rate: CHPW 22 percentage points, CUP (12 percentage points), Molina (16 percentage points), and Regence (3 percentage points)

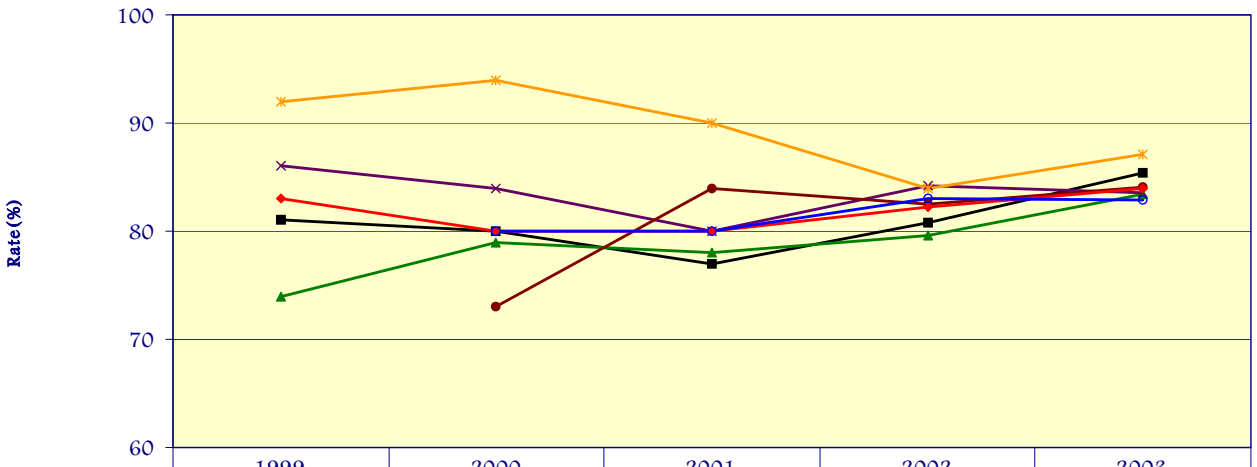
Haemophilus influenza type B (Hib).
Hib is a bacterium, usually of the nose and throat but can infect the lungs and bloodstream. Hib is spread through direct personal contact or respiratory droplets, but is not highly contagious. Hib disease can be serious and cause meningitis, permanent brain damage, blindness, deafness, joint and bone infection, and death.

The Hib vaccine is highly effective and has decreased the incidence of Hib more than 99 percent.

Medicaid Childhood Immunizations - HIB



Medicaid Childhood Immunizations - HiB



	1999	2000	2001	2002	2003	
CHPW	81	80	77	81	85 ↑	↑↑
CUP	74	79	78	80	83	↑↑
GHC	86	84	80	84	84	
Kaiser	92	94	90	84	87	
Molina		73	84	83	84	↑↑
Premera	83	80	80	82	84	
Regence		80	80	83	83	

Analysis

- Four Hib rates improved this year
- The range of rates is from 87 percent (Kaiser) to 83 percent (Regence)
- All health plan rates improved over a 5-year period except Premera

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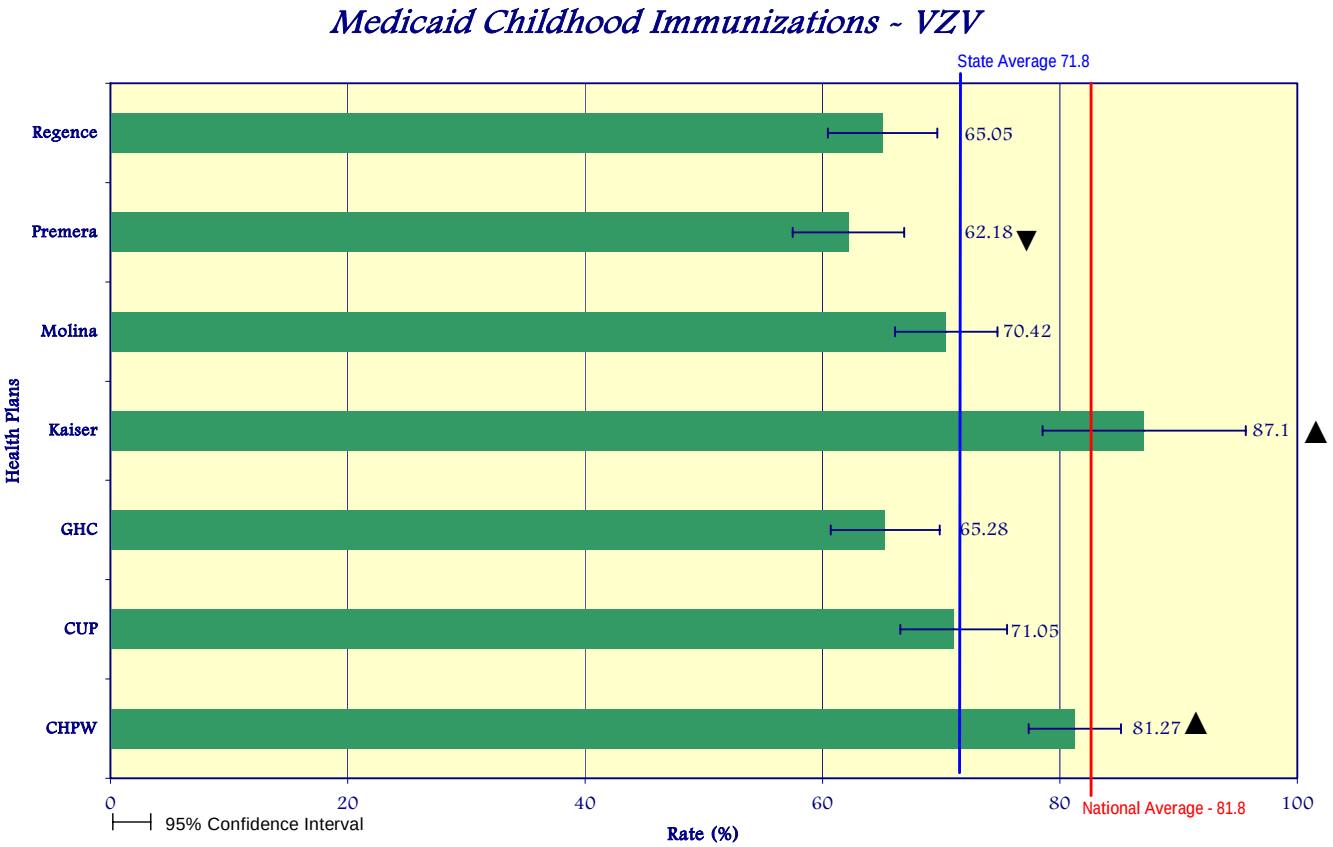
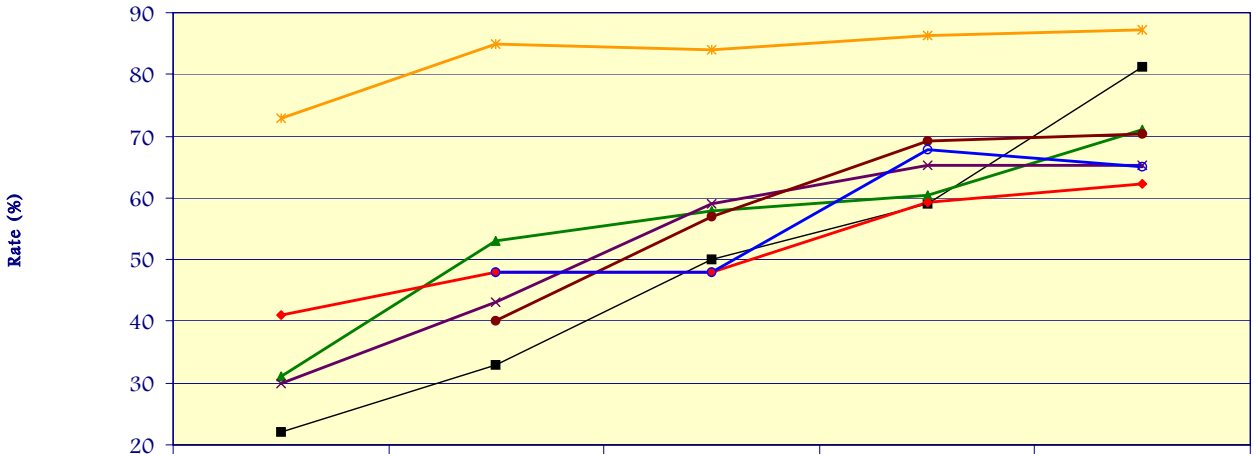
Varicella (VZV). Varicella, also called Chickenpox, is a highly contagious virus spread by an infected person through coughing or sneezing, and by contact with fluid from blisters of an infected person. The highest incidence is among elementary school aged children.

VZV is usually a more severe illness among adolescents and adults than infants. Complications are rare but serious, including skin infection, pneumonia, meningitis, and death.

Vaccination for VZV has been available since 1995 and is up to 95 percent effective.



Medicaid Childhood Immunizations - VZV



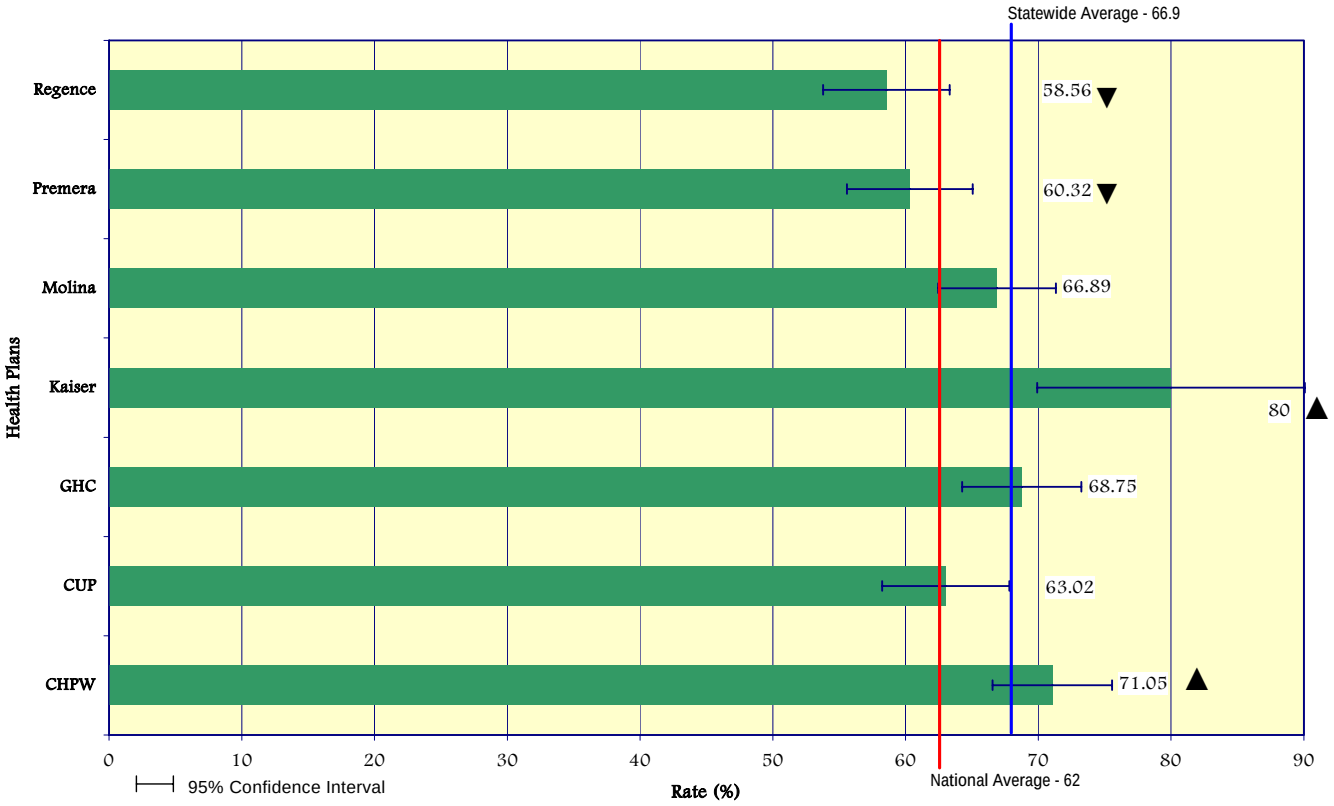
	1999	2000	2001	2002	2003	
CHPW	22	33	50	59	81 ↑	↑↑
CUP	31	53	58	60	71 ↑	↑↑
GHC	30	43	59	65	65	↑↑
Kaiser	73	85	84	86	87	↑↑
Molina		40	57	69	70	↑↑
Premera	41	48	48	59	62	↑↑
Regence		48	48	68	65	↑↑

Analysis

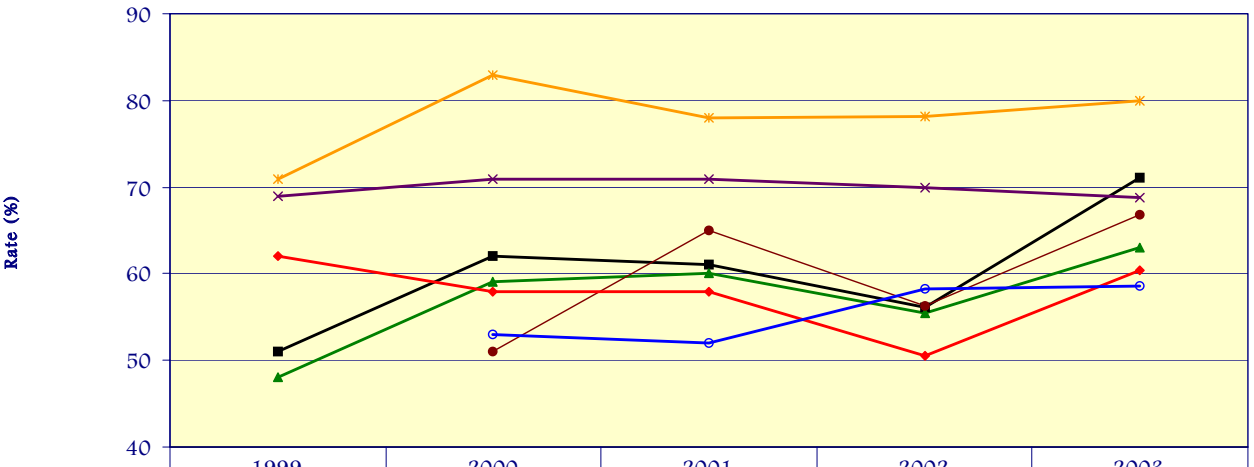
- All VZV rates except Regence improved this year
- Two health plans significantly improved the VZV rate this year: CHPW (22 percentage points) and CUP (11 percentage points)
- Over a five year period, all VZV rates improved significantly, and the lowest rate is now 40 percentage points higher than the lowest reported rate in 2000
- VZV is not a required vaccination for school attendance in Washington State. This may have some influence on why the state average for VZV is below the national average.

Combination 1 (Comb 1). NCQA uses combination measures as an aggregate rate for universally recommended childhood immunizations. Combo 1 rates are adjusted to account for changes in the measure over the years.

Medicaid Childhood Immunizations - Combo 1



Medicaid Childhood Immunizations - Combo 1



	1999	2000	2001	2002	2003	
CHPW	51	62	61	56	71 ↑	↑↑
CUP	48	59	60	55	63 ↑	↑↑
GHC	69	71	71	70	69	
Kaiser	71	83	78	78	80	
Molina		51	65	56	67 ↑	↑↑
Premera	62	58	58	50	60 ↑	
Regence		53	52	58	59	

Analysis

- All Comb 1 rates improved this year except GHC
- The Washington State average rate this year (67 percent) exceeds the national Medicaid average rate of 62 percent
- CHPW attained a 15 percentage point increase this year
- Over a 5-year period the Comb 1 statewide median rate increased from 53 percent to 67 percent with the most significant increase this year (11 percentage points)

Strategies and resources

Because of population mobility, children often visit multiple providers with incomplete immunization records and providers may defer needed vaccines or give unnecessary doses.

Healthy People 2010 set a national goal of enrolling 95 percent of children from birth through age five in a fully operational immunization registry.[14] The Washington State goal for registry participation is 95 percent provider participation by 2006. Current participation in CHILDProfile is about 44 percent. For more information about immunization registries see www.cdc.gov/nip/registry

A resource for providers to interpret client records written in a non-English language is available in English and 28 other languages at www.immunize.org Vaccine information statement (VIS), required by law to be given to the recipient before administering vaccines, are also available at that site.

Plain Talk on Childhood Immunization, developed by Public Health-Seattle and King County, Snohomish health district, and the Department of Health, is available at www.metrokc.gov/health/immunization/plaintalk2002.pdf

An electronic newsletter published by Every Child by Two (ECBT), a non-profit organization committed to promoting childhood immunizations, is available at www.ecbt.org

The Immunization Action Coalition has detailed information and photographs on childhood diseases available at www.vaccineinformation.org

A recent national teleconference focused on eliminating disparities in childhood immunizations. See www.naccho.org

A report on the most current measles research is available at www.journals.uchicago.edu/JID/journal

Founded in 1993, the Sabin Institute convenes leaders in academia, government, industry, and philanthropy to explore solutions to problems in vaccine research. A report on the global vaccine shortage is available at www.sabin.org/

[14] A fully operational registry is a confidential, population-based single data source for all community immunization partners and can reduce resources necessary to achieve immunization coverage.

Prenatal and Postpartum Care

More than a third of the births in Washington are financed by Medicaid, and nearly 89 percent of the 6,961 births to 15 to 17 year olds between 2000 and 2002 were Medicaid funded.[15]

Nationally, Medicaid rates reported by NCQA for both prenatal care and postpartum care are falling, with gaps of 34 to 44 percentage points between the top and bottom 10 percent of health plans.

Prenatal care. Early and adequate prenatal care can identify mothers at risk of delivering preterm and provide medical, nutritional and educational interventions.

Teen mothers and women who are black, Hispanic, or have low income are less likely to obtain timely prenatal care and more likely to have low birth weight (LBW) babies. LBW increases the likelihood of infant mortality, blindness, deafness, respiratory disease, mental retardation, cerebral palsy, and learning disabilities.

Nationally, the percentage of LBW infants has risen steadily since 1985, with more than 250,000 LBW infants born each year, and rates in urban areas are much higher than among the overall U.S. population.

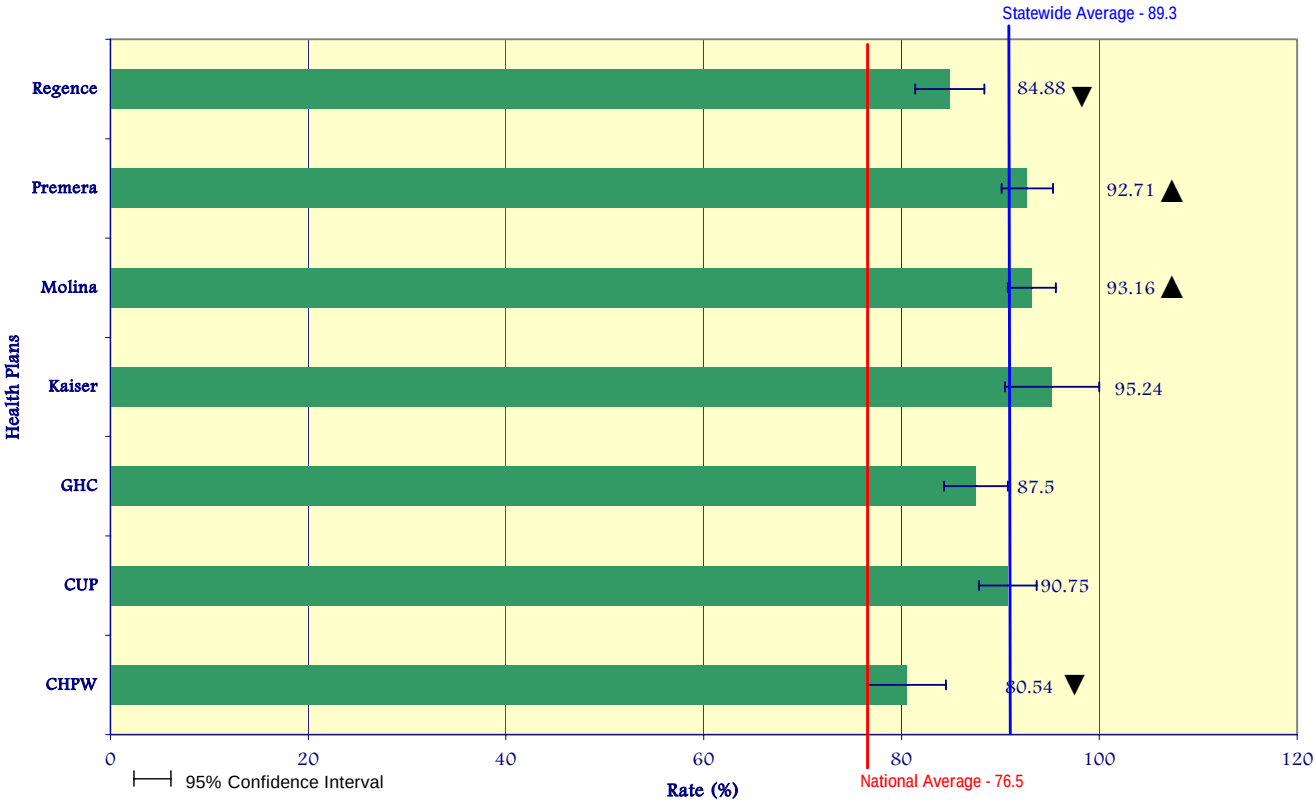
The American college of Obstetricians and Gynecologists (ACOG) recommends that prenatal care begin in the first trimester of pregnancy.

The Prenatal and Postpartum Care measure is a composite that calculates the proportion of women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, and were continuously enrolled in the health plan at least 43 days prior to delivery through 56 days after delivery, and who have prenatal care during the first 13 weeks of pregnancy, or within 43 days of enrolling if the woman enrolled after 13 weeks. The postpartum Care measure calculates the percentage of these women with live births who have a postpartum visit between 21 and 56 days after delivery.

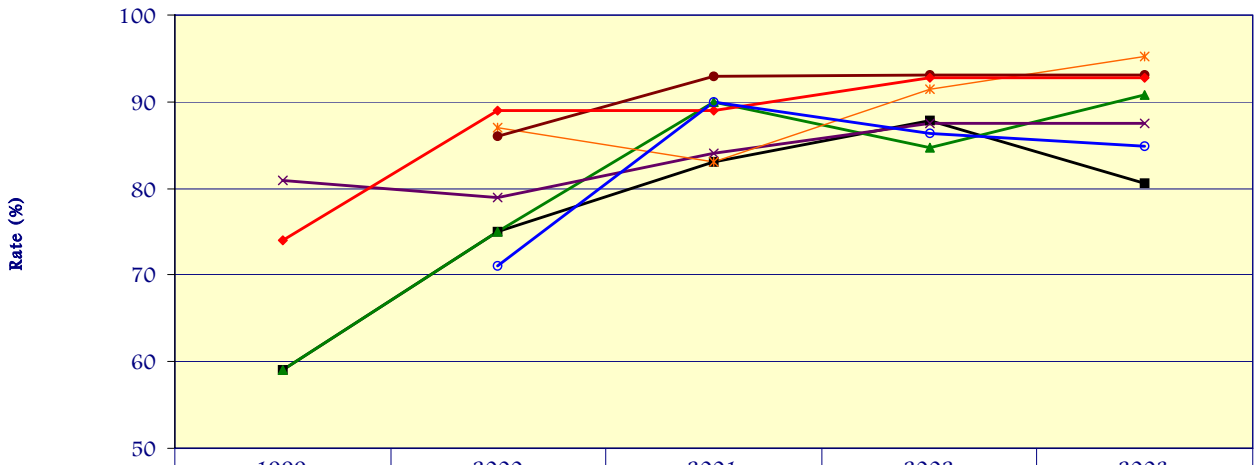
The *Healthy People 2010* goal for early prenatal care is 90 percent.

[15] Cawthon, L MD, MPH, *Medicaid Paid Maternal and Infant Services for Washington Births to Medicaid Mothers, 1990-2002*, DSHS. Research and Data Analysis Division, January 27, 2004.

Medicaid Timeliness of Prenatal Care



Medicaid - Timeliness of Prenatal Care

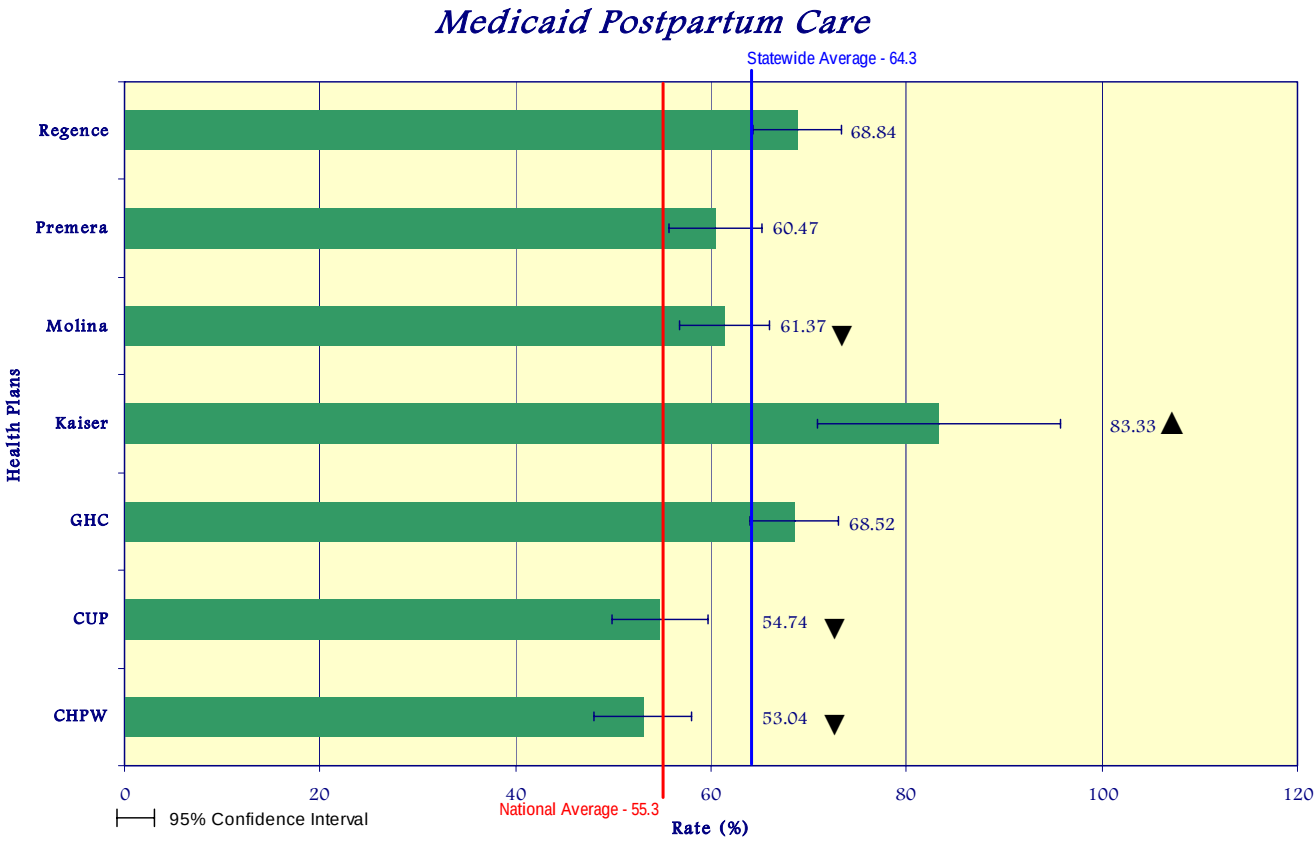


	1999	2000	2001	2002	2003	
CHPW	59	75	83	88	81 ↑	↑↑
CUP	59	75	90	85	91 ↑	↑↑
GHC	81	79	84	88	88	↑↑
Kaiser		87	83	91	95	
Molina		86	93	93	93	↑↑
Premera	74	89	89	93	93	↑↑
Regence		71	90	86	85	↑↑

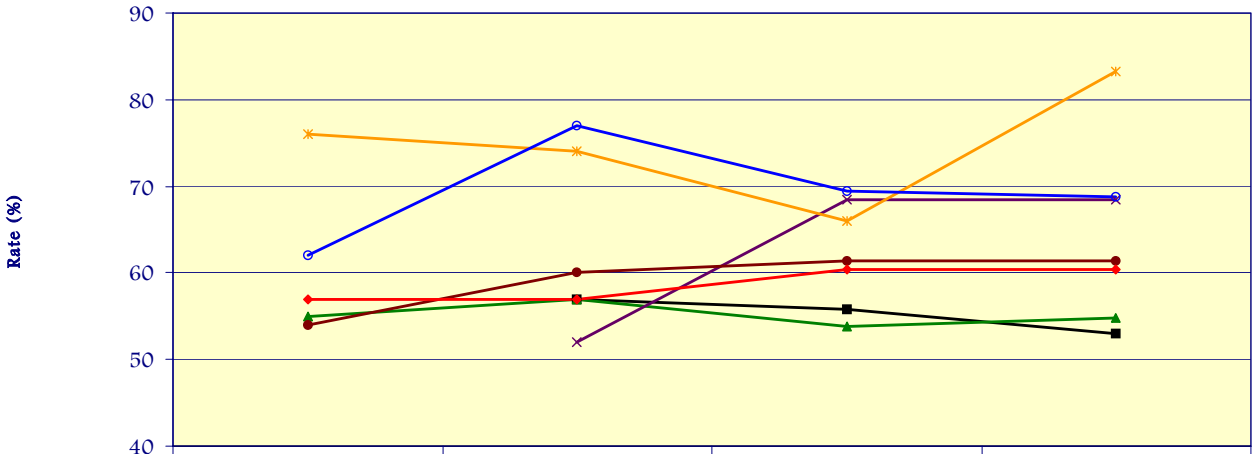
Analysis

- Only CUP improved the prenatal care rate this year
- The statewide average prenatal care rate this year is almost 12 percentage points above the national average Medicaid rate of 70 percent, and approaches the *Healthy People 2010* goal of 90 percent
- Over a 5-year period, all health plans improved and four health plans attained significant improvement: CUP 31 percentage points; CHPW 22 percentage points; PBC 19 percentage points; and Regence 14 percentage points

Postpartum care. Childbirth produces physical, emotional and social changes in the mother. The ACOG recommends that women see their health care provider at least once between four and six weeks after delivery. The postpartum visit provides clinicians the opportunity to offer guidance, counseling, and treatment, which can reduce the duration and effects of postpartum depression. One of the strongest predictors of postpartum depression is prenatal depression.



Medicaid ~ Postpartum Care



	2000	2001	2002	2003	
CHPW		57	56	53	
CUP	55	57	54	55	
GHC		52	69	69	↑↑
Kaiser	76	74	66	83	
Molina	54	60	61	61	↑↑
Premera	57	57	60	60	
Regence	62	77	69	69	↑↑

Analysis

- The Washington State average (64 percent) is above the national Medicaid average rate (55 percent)
- The range of rates is 83 percent (Kaiser) to 53 percent (CHPW)
- Two health plans improved the rate this year (CUP and Kaiser), two health plan rates dropped (CHPW and Regence), and three health plans rotated this measure this year
- Over a three-year period, four rates improved and three dropped

Strategies and resources

Safe Babies Safe Moms, a four-year program designed to help high-risk pregnant women get off drugs and alcohol, has achieved encouraging results: fewer babies at risk of fetal alcohol syndrome (one of the leading causes of mental retardation); fewer children referred to Child Protective Services; a drop in client criminal involvement; and a two-thirds drop in the rate of LBW babies.[16]

[16] *Seattle Post Intelligencer*. October 11, 2004.

Well Child and Adolescent Care

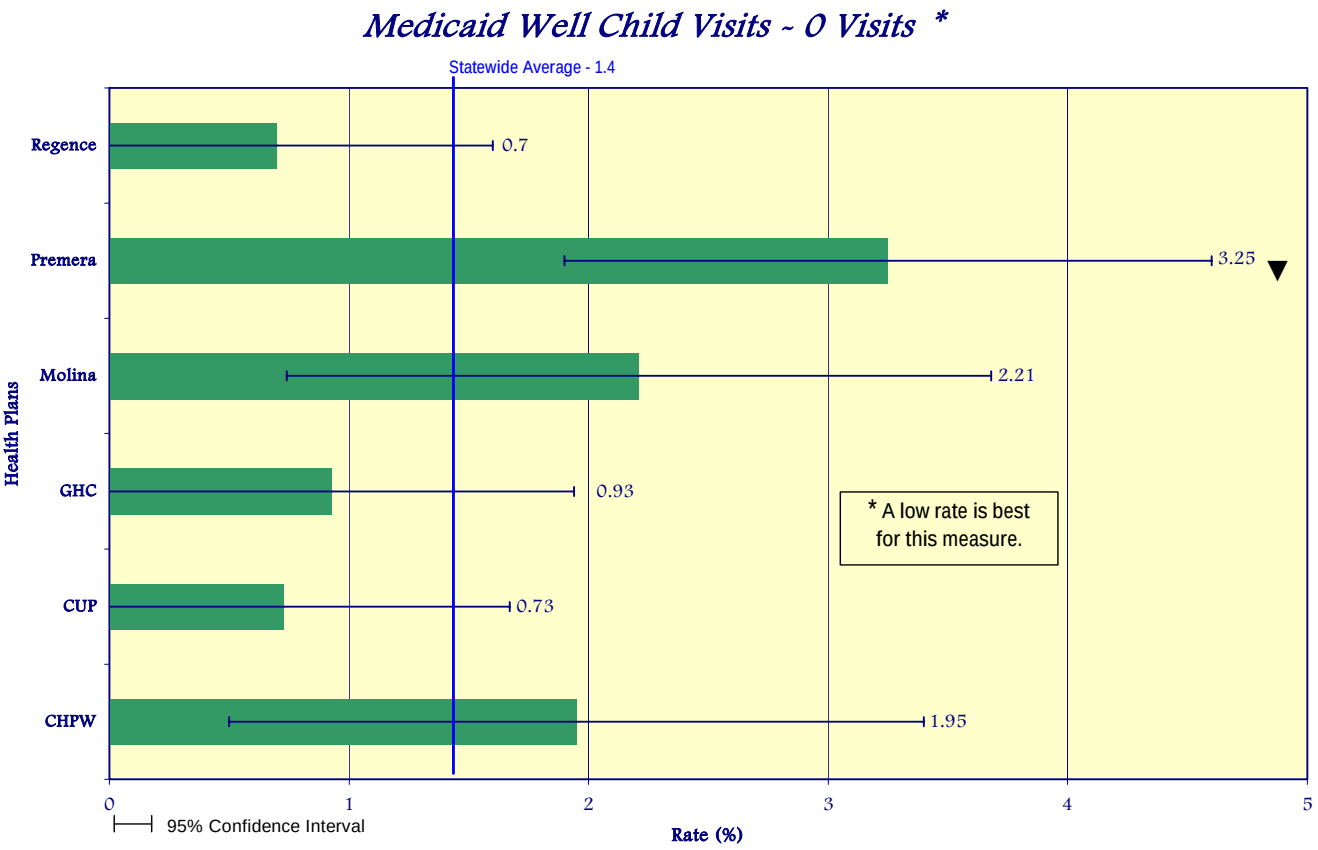
Well care visits provide opportunities to address health conditions that could affect the development of children and adolescents.

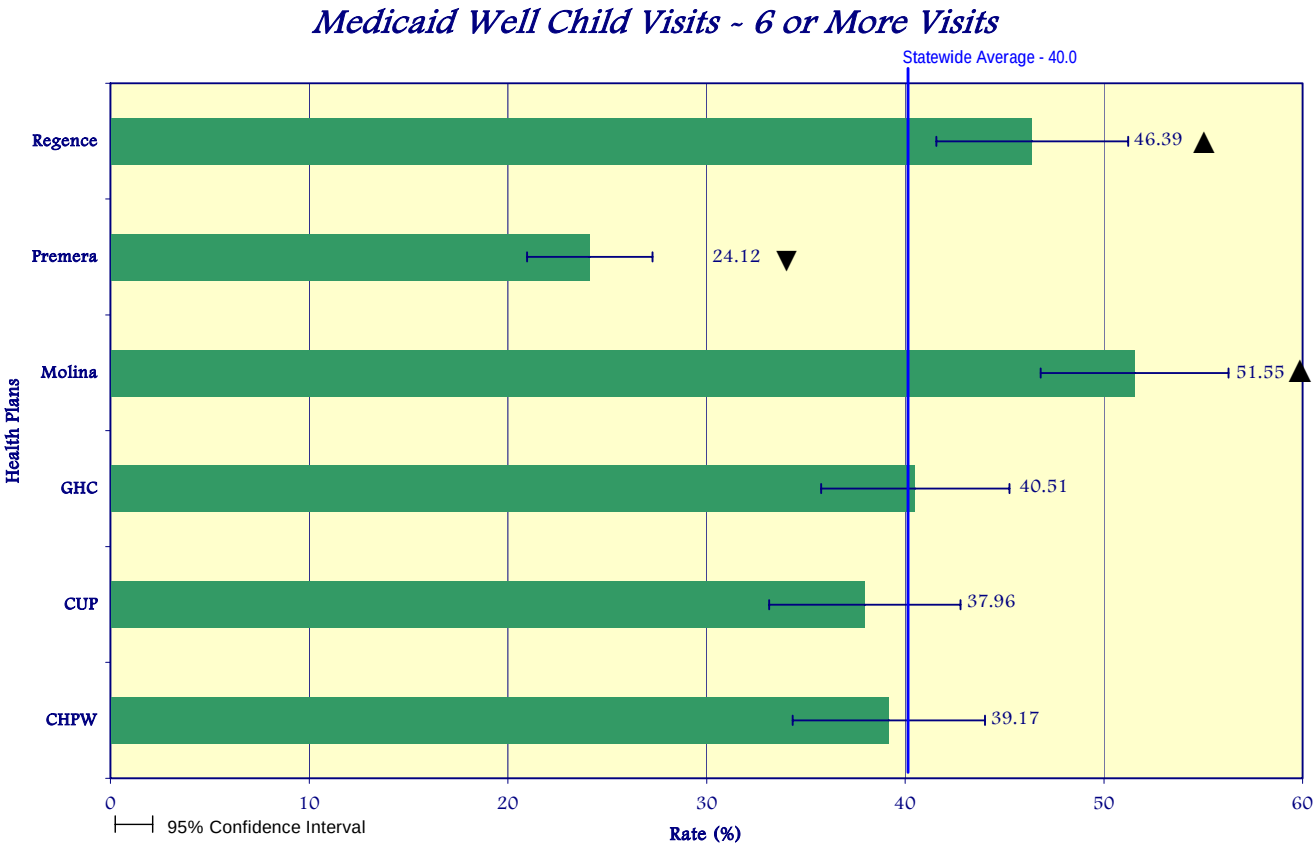
Yet according to national data, as many as 75 percent of children and adolescents aren't getting preventive care as recommended by guidelines, and only 20 percent are receiving necessary treatment, including 7.5 million children in need of mental health care.

Since 1989, federal law requires Medicaid programs to have a comprehensive preventive care program for individuals under age 21 called Early Periodic Screening, Diagnosis, and Treatment (EPSDT). Health plans are required to meet all state EPSDT guidelines, which are more specific than the HEDIS well child and adolescent care measures. For more information, see Washington State memorandums and www.cms.hhs.gov/medicaid/epsdt

Well Child Visits in the First 15 Months of Life. The American Academy of Pediatrics (AAP) recommends six well-child visits in the first year of life, including appropriate referrals to specialists and counseling and guidance to parents.

This measure is the proportion of members who turned 15 months old during the reporting year, who where enrolled from 31 days of age (allowing a one month gap in enrollment) and who received 0-6 or more preventive visits with a primary care provider during their first 15 months of life.





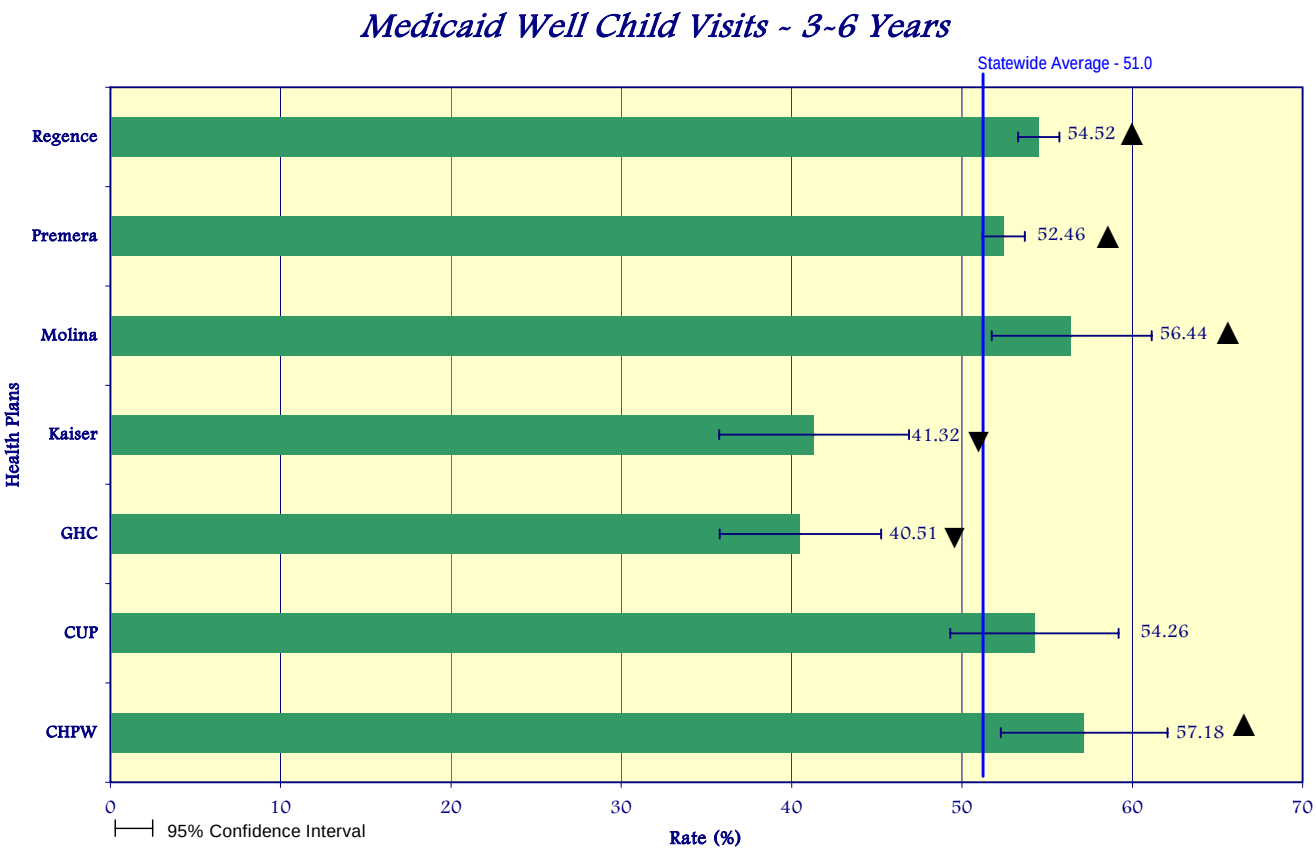
Analysis

- Regence both improved the rate of members with six visits (from 16 percent to 46 percent) and reduced the rate of members with no visits (from 5 to less than 1 percent) this year
- All health plans with more than 30 eligible members significantly improved the rate for 6 visits except CHPW, which dropped from 41 percent to 39 percent; the CUP rate was unchanged
- Three health plans improved the 6 visit rate: Premera (15 percentage points); GHC (10 percentage points), and Molina (6 percentage points)
- All health plans reporting this rate (except Molina) also reduced the no visit rate this year
- 99 percent of eligible children in CUP, GHC and Regence get at least one well child visit in the first 15 months of life
- CUP reduced the no visit rate from 2 percent to less than 1 percent
- Although Premera has the highest rate for members with no visits again this year, the rate decreased from nearly 7 percent to just over 3 percent

Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life.
Preventive visits during the preschool and early school years allow clinicians to detect vision, speech, language, and learning problems.

The AAP recommends annual well-child visits for children three to six years of age. Yet, according to a recent Commonwealth report, which is based on data from dozens of separate studies, as many as 50 percent of parents are never asked by a clinician about their child's speech or language development.

This measure is the proportion of children ages 3, 4, 5, and 6 years of age during the measurement year, who were continuously enrolled in the health plan during the measurement year and who received one or more well-child visit(s) with a primary care practitioner during the measurement year.



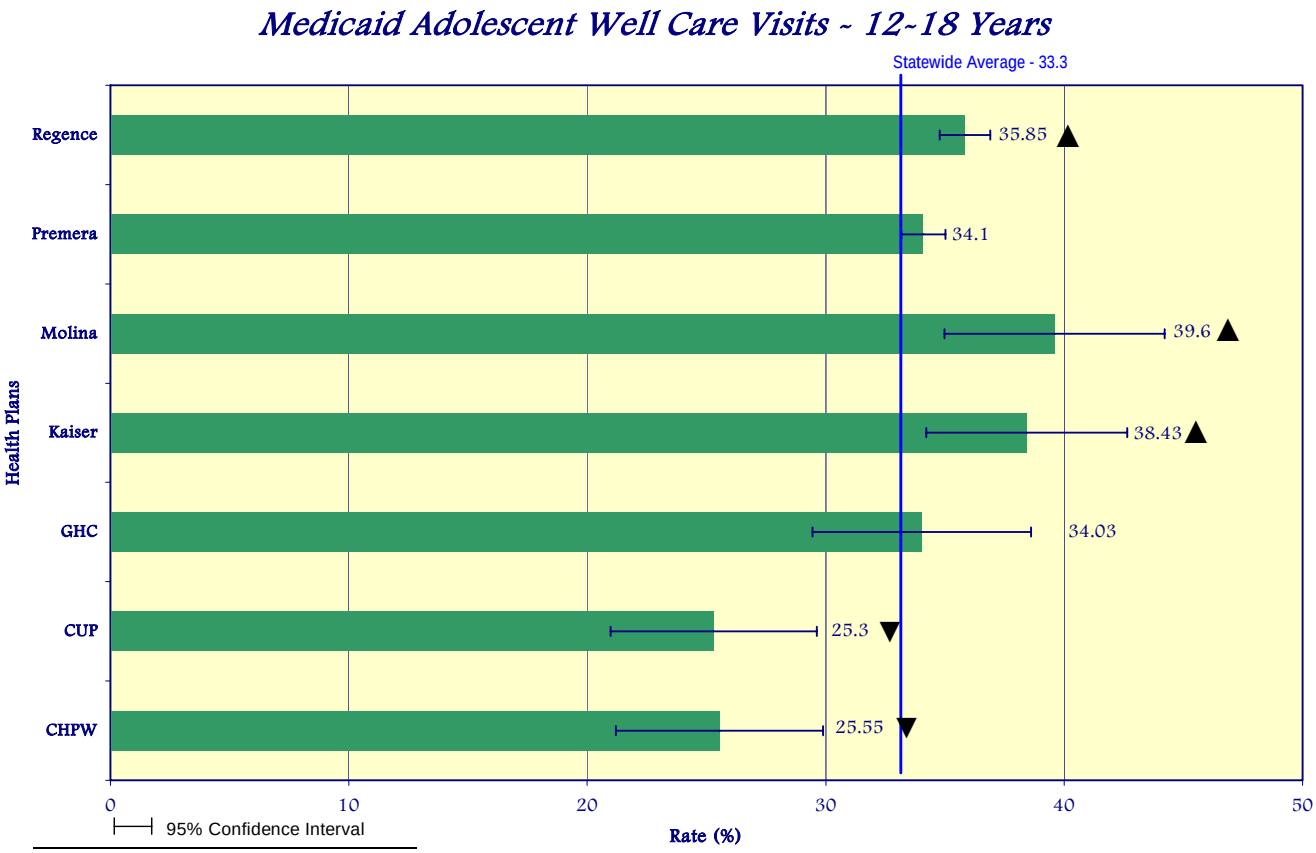
Analysis

- Five health plans improved the well child visit rates for this age group this year: CUP, CHPW, GHC, Kaiser and Premera
- The range of rates is from 57 percent (CHPW) to 41 percent (GHC)
- GHC and Kaiser are significantly below the statewide average of 51 percent for this age group

Adolescent Well Care Visits. Although adolescents are generally a healthy population, adolescence is a period where more changes take place in anatomy, physiology, mental and emotional functioning, and social development than any other life stage, except infancy. Many adolescents engage in risk taking behaviors and many lifelong health habits are formed. Violence among adolescents is a critical public health issue in the U.S. with homicide the second leading cause of death among persons aged 15 to 24 in 2000.[17] The American Medical Association, the Bright Futures program, and the AAP all recommend comprehensive annual checkups for adolescents to address health conditions such as obesity, sexually transmitted diseases, substance abuse, and other risk behaviors.

The proportion of enrolled members who were 12-21 during the measurement year, who were continuously enrolled during the measurement year and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

The Partnership for Prevention research cited earlier in this report scored 8 of 10 points on prevention priorities for assessment of adolescent drinking and drug use and counsel on abstinence. However, the Commonwealth report (also cited earlier) found that less than 50 percent of adolescents ever discuss health topics such as sexually transmitted diseases, pregnancy prevention, or alcohol usage with a health care practitioner.



[17]See www.mchb.hrsa.gov

Analysis

- GHC, Kaiser, and Premera improved adolescent well care rates this year
- Rates range from 40 percent (Molina) to 25 percent (CUP)
- On average, only a third of the adolescents in the Medicaid population in health plans are getting annual preventive care visits

Strategies and resources

A report on indicators of child wellness published by the Federal Interagency Forum on Child and Family Statistics is available at http://www.childstats.gov/americaschildren/

Healthy Kids Now is a statewide, joint outreach effort between public and private partners designed to help low-income children in Washington get health coverage.

The Women Infants and Children (WIC) program provides short-term low cost preventive health services to families who are at risk due to low income and nutritionally related health conditions.

A *Kids Count 2004 Data Book Online* is available at www.aecf.org/kidscount/databook/indicators.htm

Use of Appropriate Medication for People with Asthma

Asthma is a reversible obstructive lung disease, caused by inflammation, constriction of airflow in the bronchial tubes and excess mucous production. An asthma attack can be life-threatening if not properly managed or controlled.

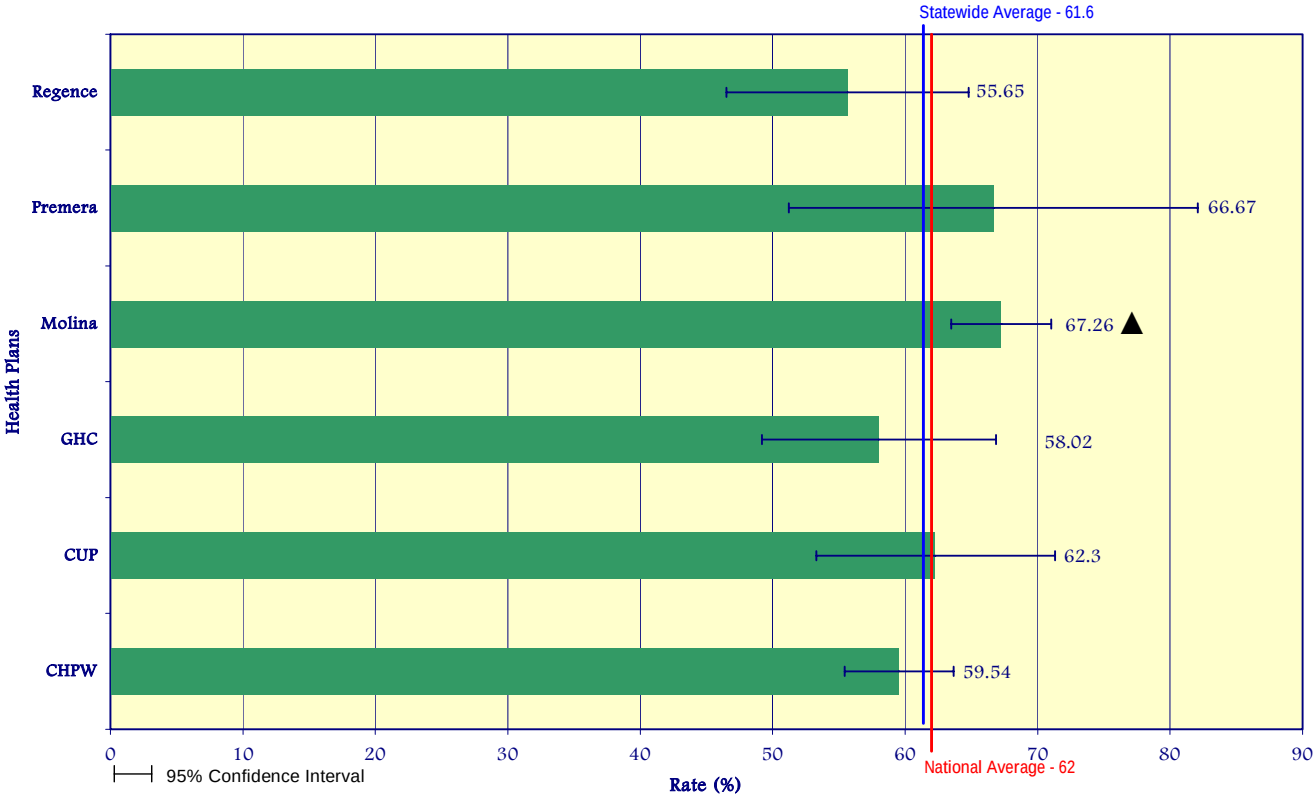
Asthma is the sixth ranking chronic condition in the U.S. The incidence of asthma is increasing nationwide and in Washington State, where asthma affects over 600,000 people. At particular risk are children, minorities, the elderly, women, and those with lower income levels.

This measure calculates the proportion of members with persistent asthma (defined as previous year's service and medication utilization) prescribed medications acceptable as primary therapy for long-term control of asthma. Inhaled corticosteroids are the preferred primary therapy. Long-acting beta-agonists are not counted when used independently.

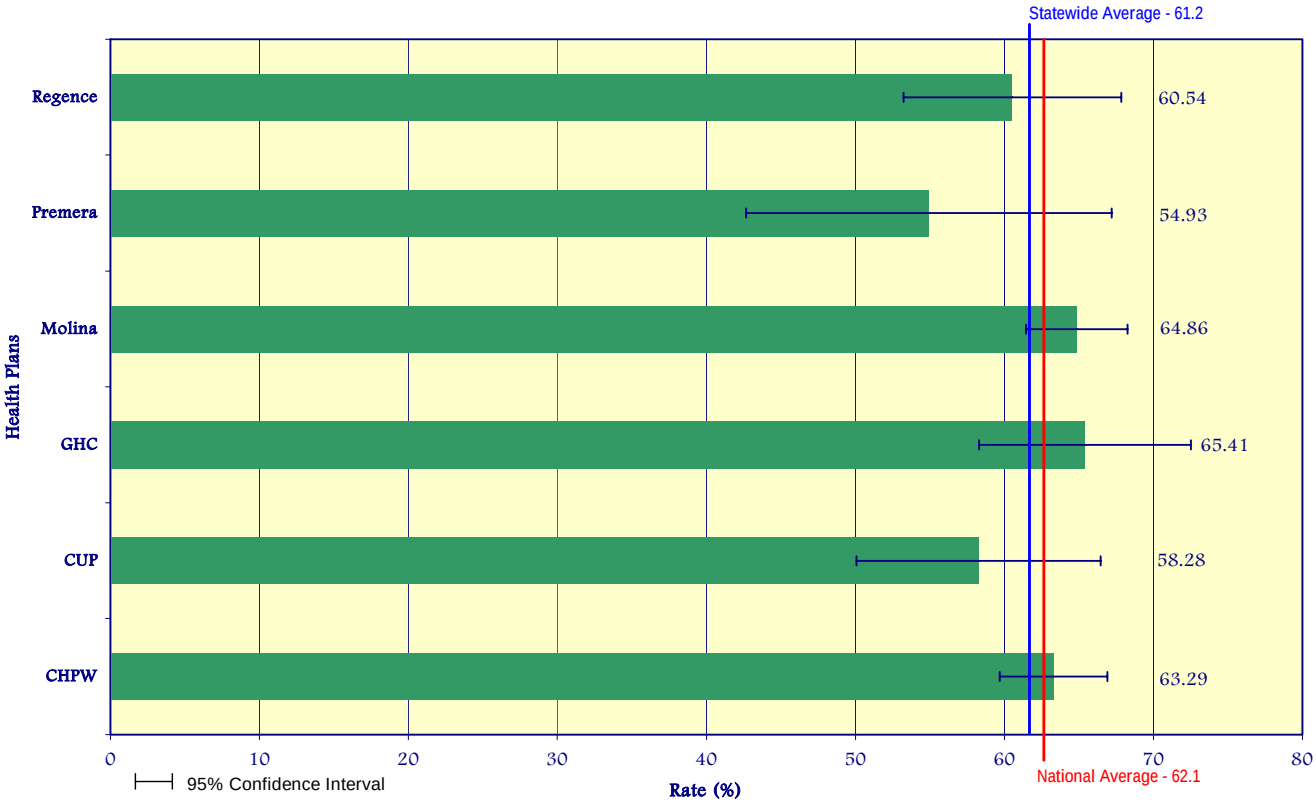
The best available evidence demonstrates that inhaled corticosteriods are the preferred primary therapy for long-term control of asthma. This HEDIS measure is designed to evaluate whether members with persistent asthma are prescribed corticosteriods. All rates for this measure use the administrative method and are reported for three age groups. A combined rate is also reported.

Improving life, one breath at a time
American Lung Association of Washington

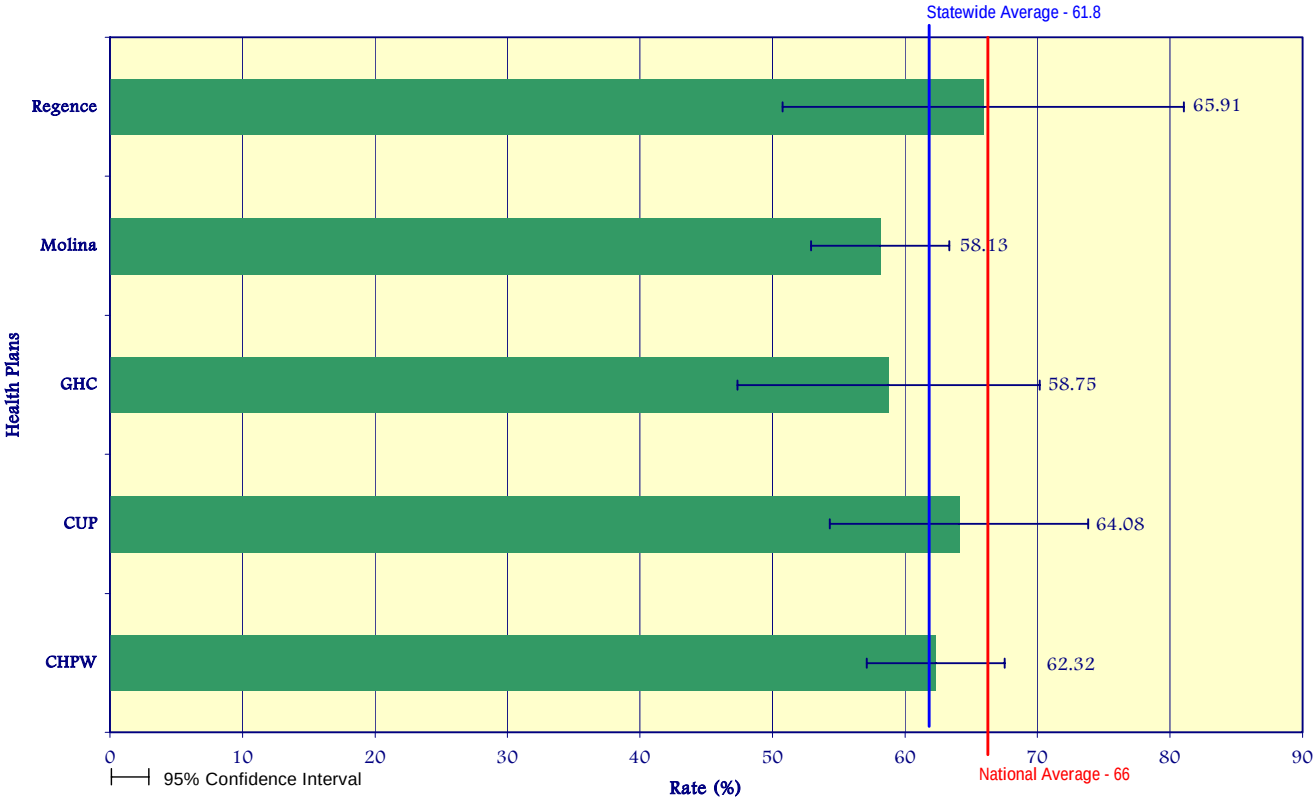
Medicaid Medication Use for People with Asthma - Ages 5-9



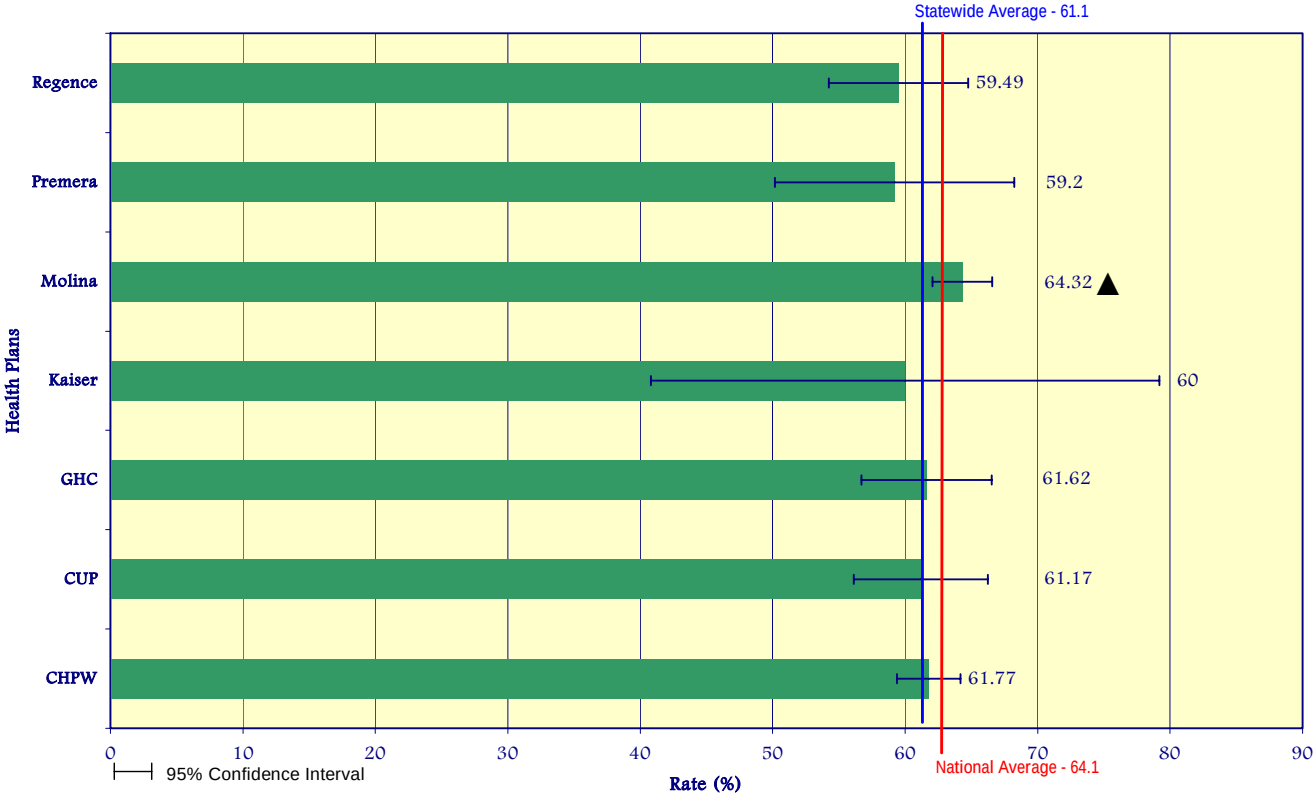
Medicaid Medication Use for People with Asthma - Ages 10-17



Medicaid Medication Use for People with Asthma - Ages 18-56



Medicaid Medication Use for People with Asthma - Combined



Analysis

5-9 year olds:
- All health plans except CUP and GHC improved the rate this year for this age group
- Kaiser did not have enough members to report this age group
- Rates range from 67 percent (Molina) to 56 percent (Regence)
- The statewide average for this age group fell 4 percentage points this year

10-17 year olds:
- Three health plans improved the rate this year for this age group: CHPW, GHC, and Molina
- Three rates for this age group dropped this year: Premera, CUP, and Regence
- Kaiser did not have enough members to report this age group

18-56 year olds:
- CHPW and CUP improved the rate for this age group this year

Combination rate:
- CHPW significantly improved the Combination rate this year (from 52 percent to 62 percent)
- Four rates dropped this year (GHC, Kaiser, Premera, and Regence)
- Kaiser and Premera do not have enough members to report this age group
- The Washington State average (61 percent) is under the national average rate (64 percent)

Strategies and resources

The Washington Asthma Initiative, a statewide coalition of over 52 organizations, produced the Washington State Asthma Plan—a statewide comprehensive 10-year year strategy to improve prevention, diagnosis, and management of asthma and decrease individual and societal burdens. For more information, see www.alaw.org

The National Asthma Education and Prevention Program (NAEPP) keeps clinical practice guidelines up to date. The NAEPP Expert Panel Report, *Guidelines for the Diagnosis and Management of Asthma—update on Selected Topics 2002*, is available at www.nhlbi.nih.gov

The King County Asthma Forum offers useful information on its website www.metrokc.gov

A CDC guide to school asthma management is available at www.cdc.gov/healthyyouth

The National Institute for Environmental Health Science examines environmental hazards on children's health and development, health disparities, and culturally relevant activities for economically disadvantaged and underserved communities in a brochure available at http://www.niehs.nih.gov

The Allergy and Asthma Disease Management Center (AADMC) website provides practical and timely information to physicians. It is available at www.aaaai.org/aadmc

Comprehensive Diabetes

Diabetes is a complex, costly, chronic condition characterized by an inability of the body to produce or utilize insulin, which is needed by the body to metabolize glucose.

Approximately 16 million Americans have diabetes. The prevalence of diabetes increases with age and is higher among certain racial and ethnic populations. Prevalence appears to be more strongly associated with poverty than with education or occupational status.[18] Washington follows the national pattern for diabetes death rates by race, however for Asians and Pacific Islanders in Washington, the death rate is higher than for this group nationally.

People with diabetes are at increased risk for blindness, kidney disease, foot and leg amputations, and heart disease. Early detection and treatment can significantly reduce complications.

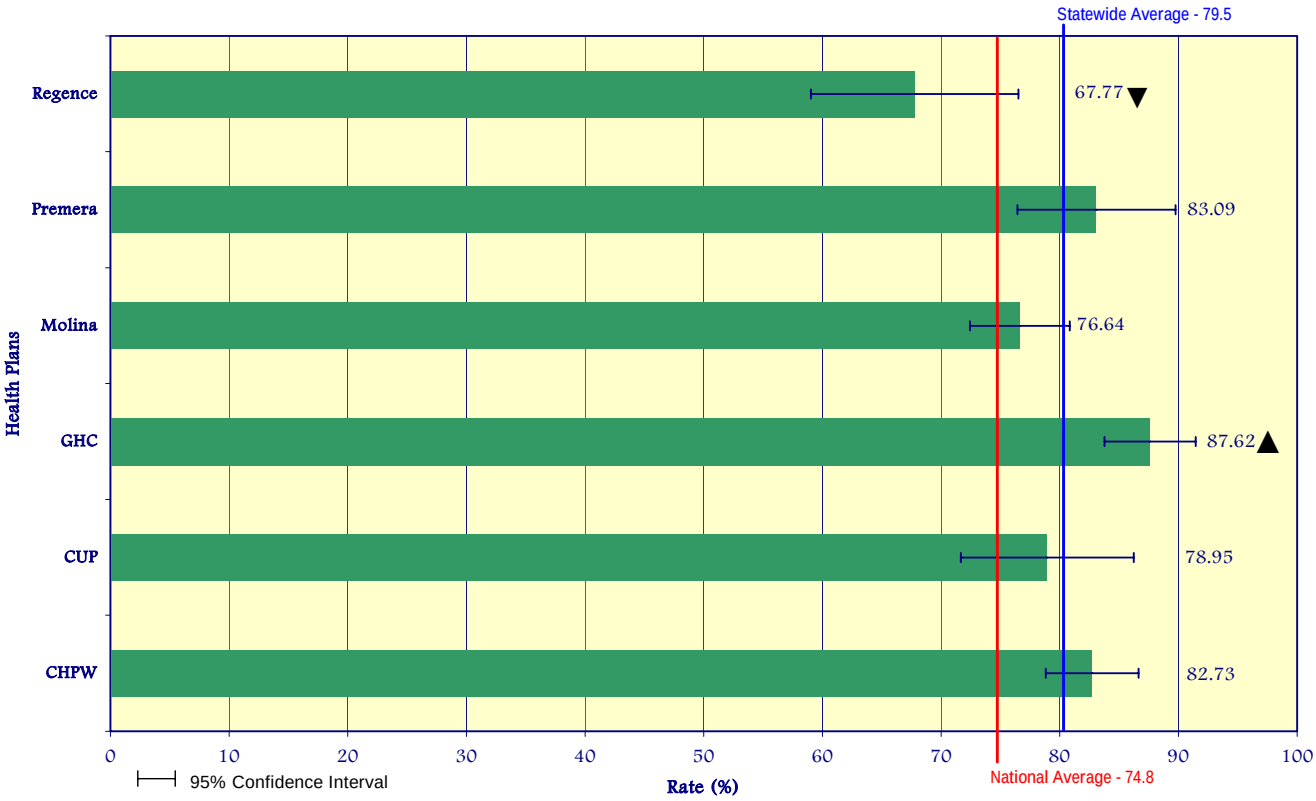
The Comprehensive Diabetes measure contains seven separate indicators.

This measure calculates the proportion of members aged 18 to 75 years with diabetes (type 1 and type 2) who were continuously enrolled during the measurement year and who had each of the following (seven separate indicators):

Hemoglobin A1c (HBA1c) tested
HbA1c poorly controlled (>9.5%)
LDL-C screening performed
LDL-C controlled (LDL<130 mg/dL)
LDL-C controlled (LDL<100 mg/dL)
Eye exam (retinal) performed
Kidney disease (nephropathy) monitored

HbA1c Testing. It is estimated that for every one percent reduction in blood glucose levels, the risk of developing eye or kidney disease, or lower-extremity amputation drops by 40 percent.

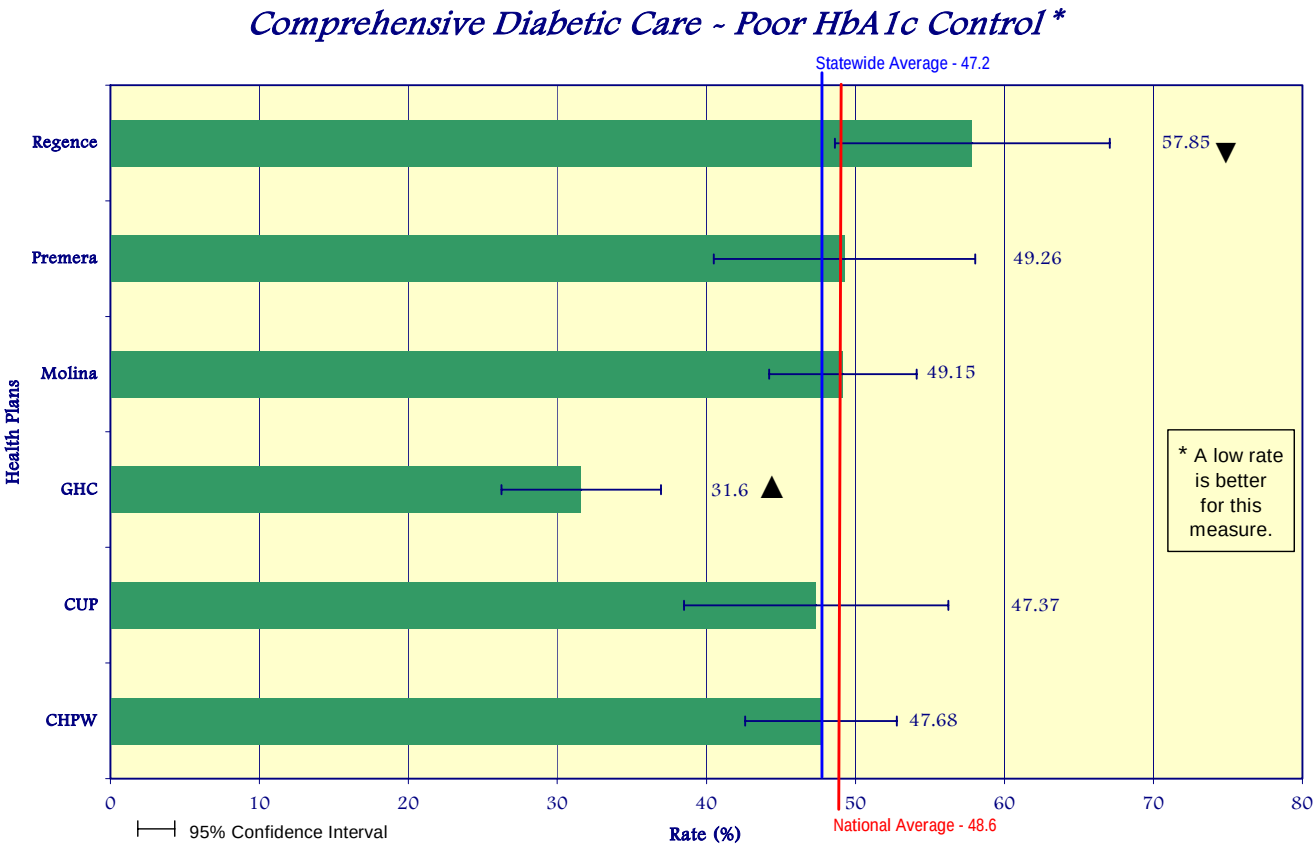
[18] Centers for Disease Control and Prevention. The Burden of chronic Diseases and Their Risk Factors: National and State Perspectives 2004. http://www.cdc.gov/nccdphp/burdenbook2004.



Analysis

- The rates for HbA1c testing range from 88 percent (GHC) to 68 percent (Regence), a spread of 20 percentage points
- GHC is significantly above the statewide average (80 percent), and exceeds the national average Medicaid rate (75 percent)

Poor HbA1c Control. This rate reports the proportion of members in a health plan whose HbA1c rate was not controlled (i.e., the most recent HbA1c level is over 9.5 percent or the level was not obtained). A low rate is best for this measure, i.e., a low rate of poor control indicates better care.

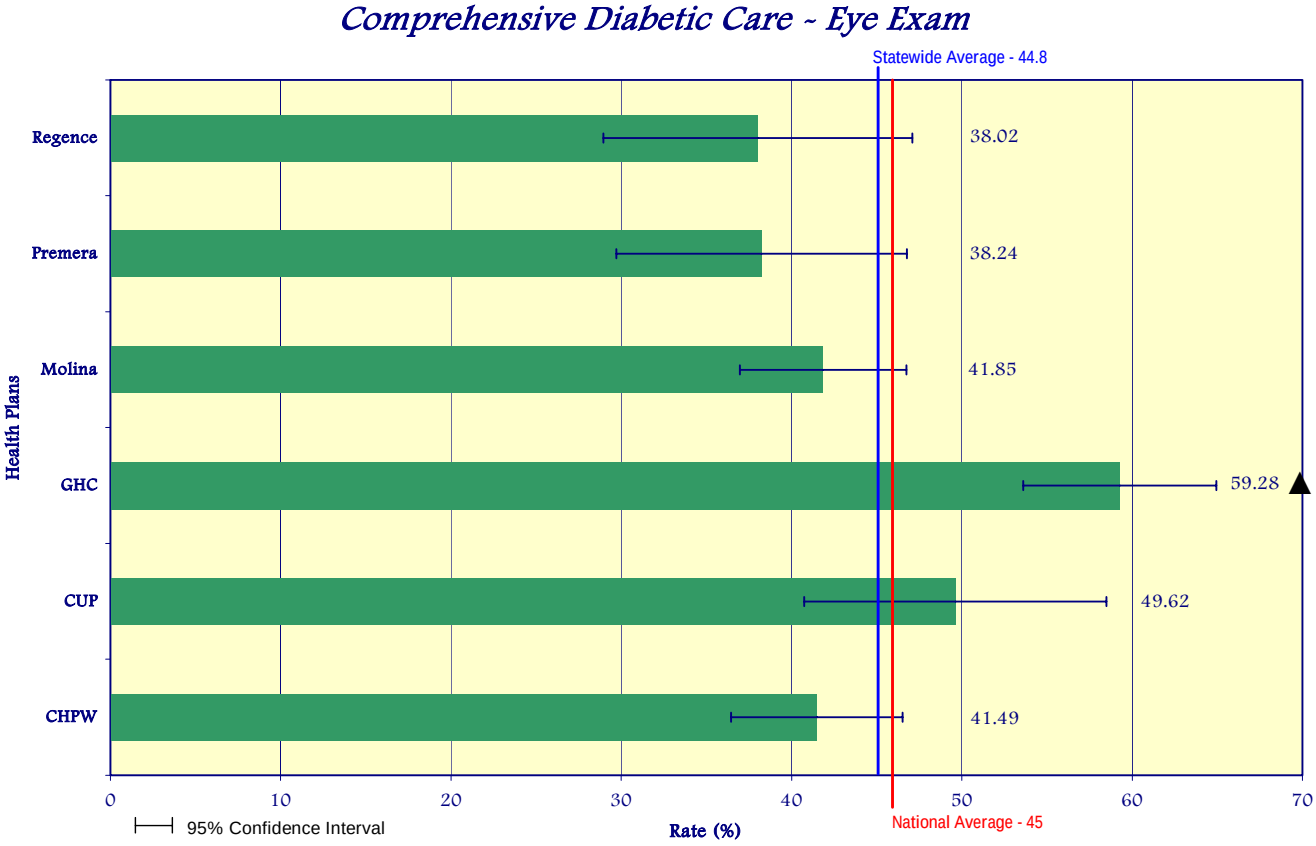


Analysis

- On average, in the Medicaid population, almost half the persons with diabetes in health plans did not have adequate control of HbA1c levels this year (about the same as the national average Medicaid rate)

Eye Exam. Diabetic retinopathy is one of the most common complications associated with diabetes and the leading cause of blindness, causing up to 24,000 new cases of blindness every year.

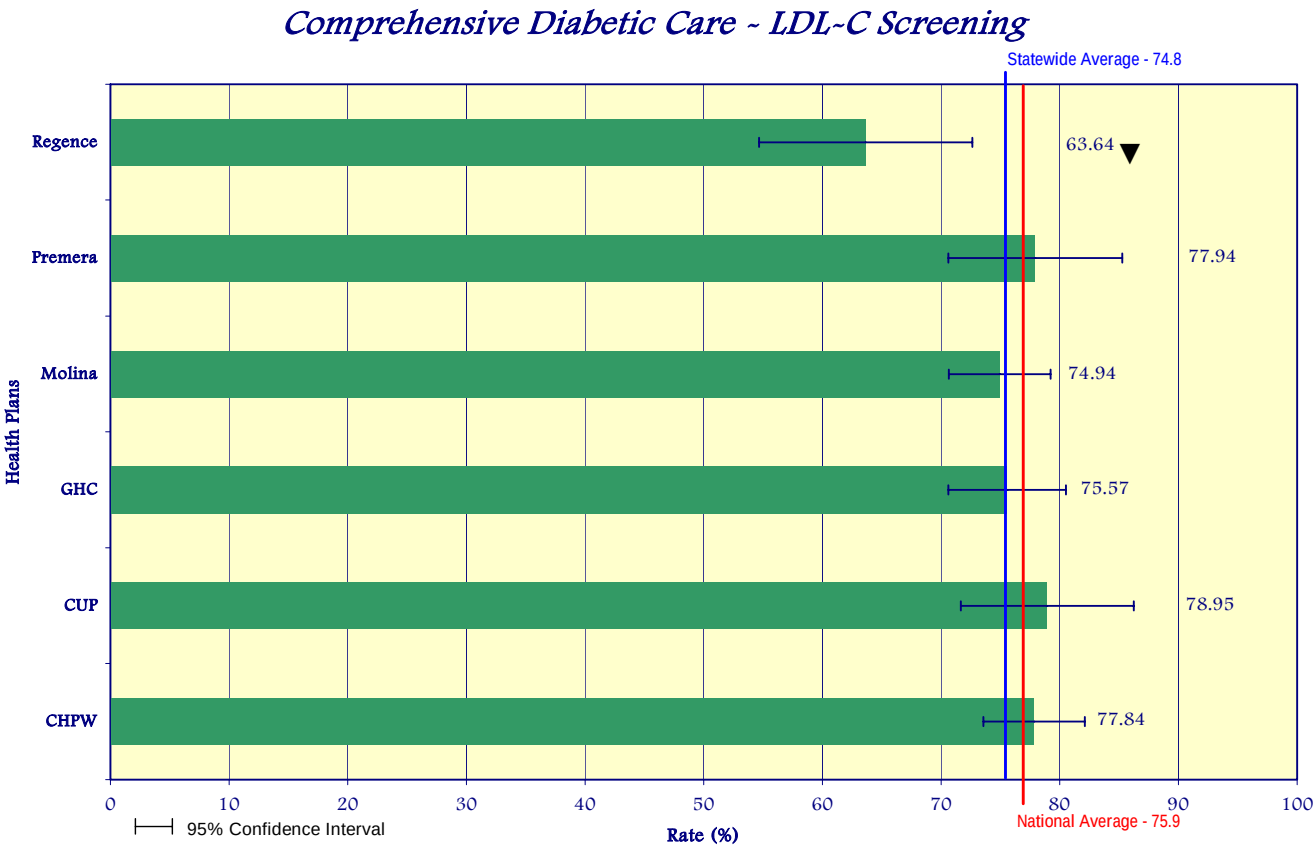
Studies have established that intensive diabetes management at an early stage can prevent and delay the progression of diabetic retinopathy.



Analysis

- The range of rates is from 59 percent (GHC) to 38 percent (Regence)
- The Washington state average (45 percent) is the same as the national Medicaid average

LDL-C Screening. LDL is a lipoprotein that carries cholesterol in the blood and is considered to be undesirable because it deposits excess cholesterol in the walls of blood vessels and contributes to heart disease. LDL screening measures the amount of LDL cholesterol in blood.

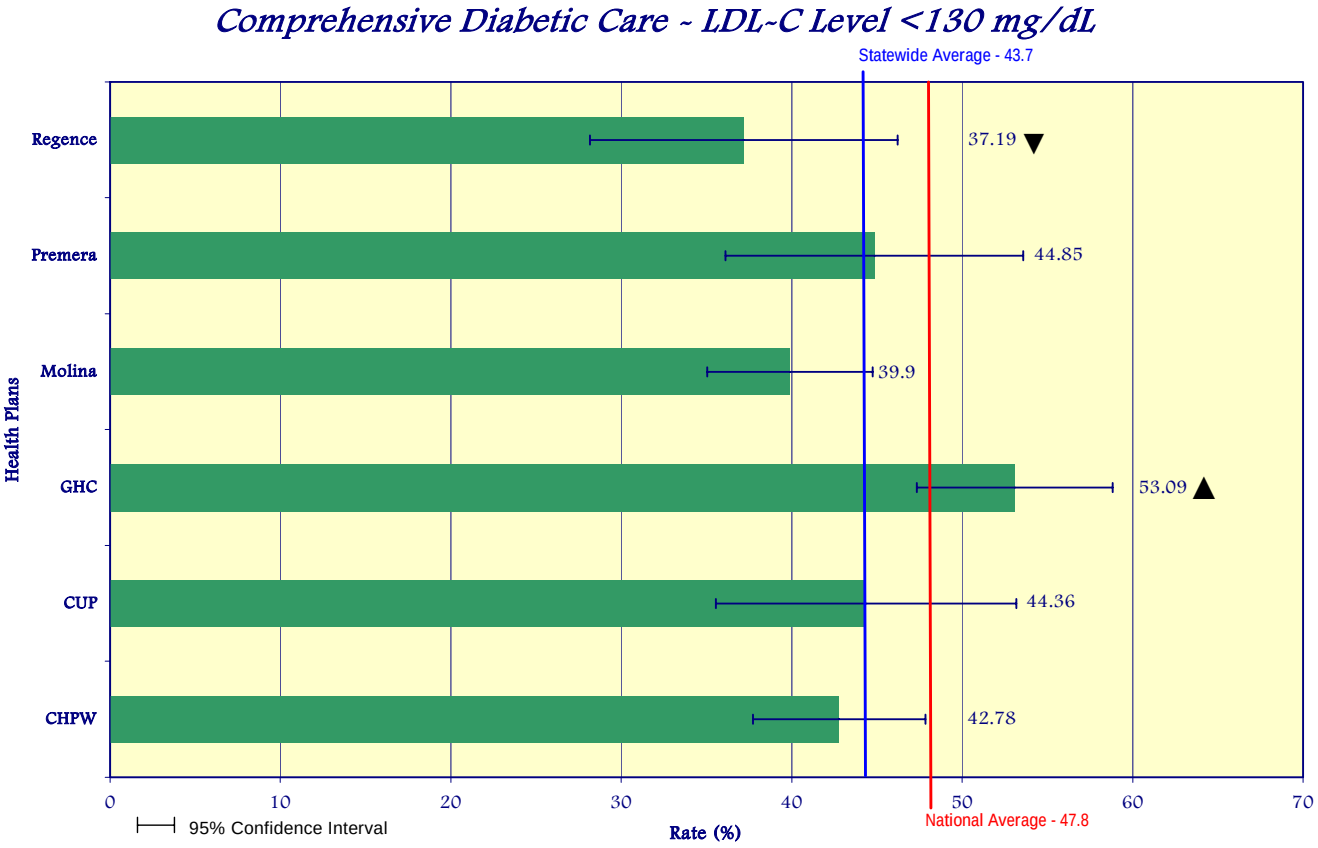


Analysis

- The range of rates is from 79 percent (CUP) to 64 percent (Regence)—a 15 percentage point variance across health plans
- The Washington statewide average rate (75 percent) is just under the national Medicaid average (76 percent)

LDL-C Level <130 mg/dl.

This measure is intended to show how well LDL is controlled by the percent of members with an LDL level below 130 mg/dcL in the last two measurement years.

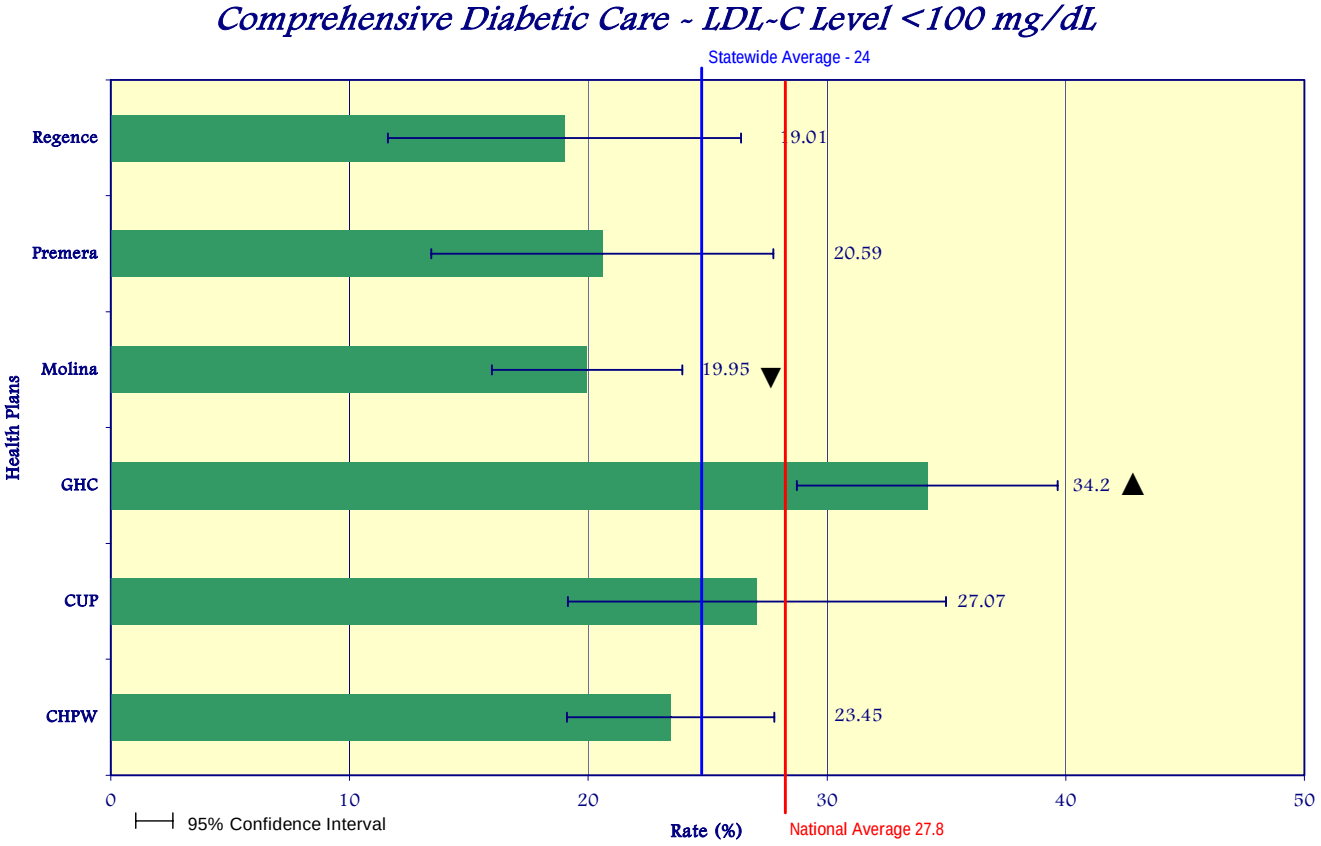


Analysis

- The range of rates is from 53 percent (GHC) to 37 percent (Regence)
- The statewide average (44 percent) is below the national Medicaid average (48 percent)

LDL-C Level < 100 mg/dl

This measure was added this year due to new national cholesterol educational guidelines.

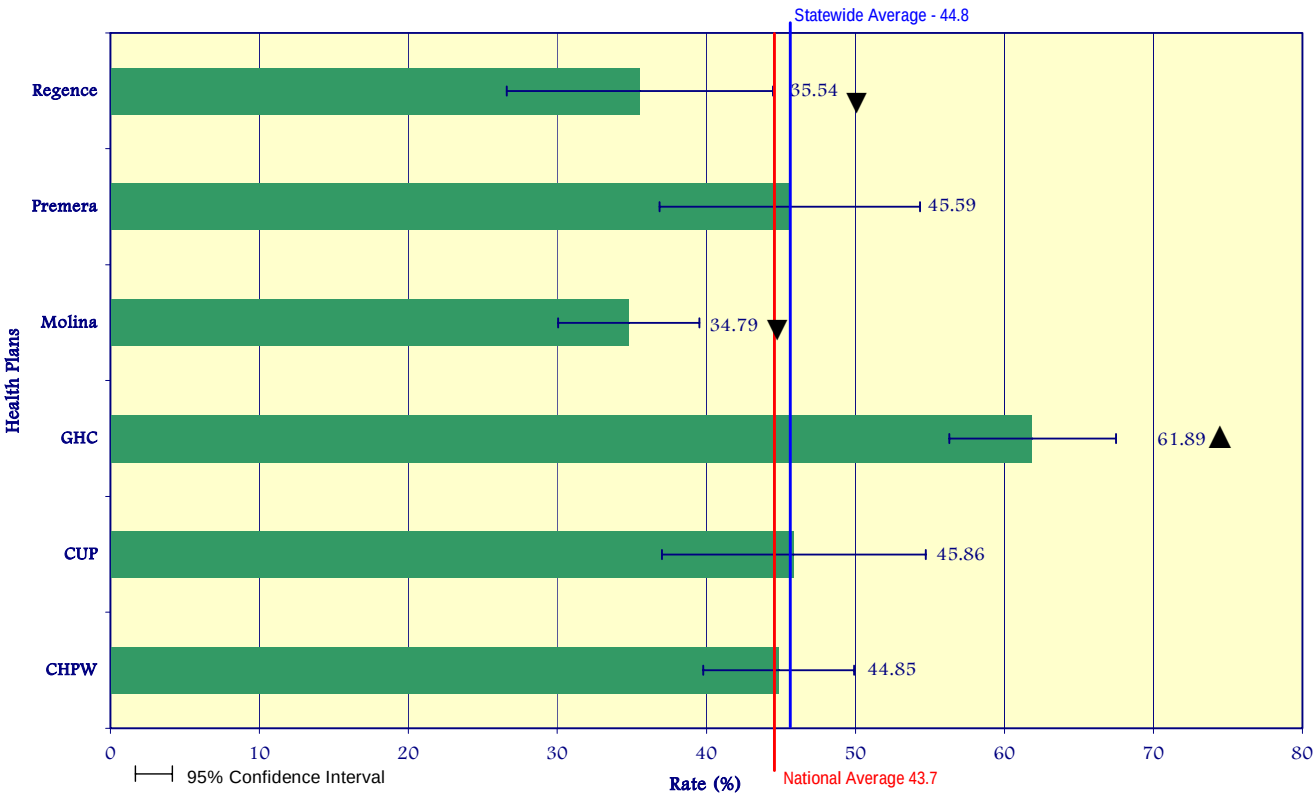


Analysis

- The range of rates is from 34 percent (GHC) to 19 percent (Regence)
- The statewide average (24 percent) is below the national Medicaid average rate (28 percent)

Monitoring for Diabetic Nephropathy. Diabetes is a major cause of kidney disease, and the leading cause of end-stage renal disease (ESRD), accounting for about 40 percent of newly diagnosed cases. Nationally about 100,000 Americans have kidney failure as a result of uncontrolled diabetes.

This rate is intended to assess whether persons with diabetes are being monitored for nephropathy.



Analysis

- The range of rates is from 62 percent (GHC) to 35 percent (Molina)—a 27 percentage point variance
- The statewide average (45 percent) is just above the national Medicaid average (44 percent)

Strategies and resources

Comprehensive programs implemented by health plans can help reduce the prevalence, impact, and economic costs associated with chronic illnesses, such as those implemented by the Washington State Diabetes Collaborative. The Collaborative has also implemented strategies to eliminate cultural disparities in diabetes care. Many useful strategies can be found on the Collaborative website www.doh.wa.gov

III. GENERAL STRATEGIES

NCQA lists many general strategies and recommendations for improvement of HEDIS rates in the annual *State of Health Care Quality* report. NCQA also produces a resource of successful quality initiatives used by health plans as examples to help other health plans with similar challenges. The database, *Quality Profiles*, is featured on the NCQA website. Various state, federal, regional and national organizations interested in healthcare quality improvement publish "tried and tested" strategies as well as new ideas for improving preventive services. Many of these are included in previous Washington State HEDIS reports and throughout this report.

The *Healthy People 2010* goal is to eliminate—not just reduce—disparities in health status in the U.S. A number of evidence-based interventions within the health care system that are designed to eliminate health disparities, including use of bilingual providers, cultural competency training for health care providers, use of linguistically and culturally appropriate health education materials, and culturally specific health care settings are recommended in a guide available at http://www.thecommunityguide.org/

Health resources of special interest to Asian Americans, Native Hawaiians, and other Pacific Islanders is available at www.healthfinder.gov

IV. SUMMARY

Washington State health plans warrant recognition for accomplishments this year. The majority of individual health plan rates improved. Trends demonstrate significant improvement for all health plans over a four or five year period on at least one measure.

Washington State exceeds the national Medicaid averages in the prenatal and postpartum care measures and in all childhood immunization measures except VZV.

National data in the annual *State of Health Care Quality* report show widespread variation across regions of the country. NCQA presents the impact on the health of Americans and potential cost reductions for the U.S. healthcare system if all health plans performed at the level of the top ten percent. The data raise our consciousness and provide motivation to respond.

To pursue perfection in health care and realize the vision of meeting individual needs requires the collaborative actions of public and private sector providers and community organizations. Commitment to accountability is essential.

Washington State is committed to the goal of excellent health care for all residents and to continuing this pursuit. Each health plan contributed to the significant statewide results evidenced in this report. Individual commitment matters.

Rates for clinical preventive services are improved one step at a time, not by giant leaps.

V. COMMERCIAL POPULATION

The commercial population represents all 39 counties. Molina and Premera did not submit HEDIS rates for the commercial population this year and are not represented in this report. CHPW and CUP submitted NR for some measures this year. The HEDIS measures reported for the commercial population include:

- Childhood Immunizations
- Adolescent Immunizations
- Breast Cancer Screening
- Cervical Cancer Screening
- Beta Blocker Treatment after a Heart Attack
- Comprehensive Diabetic Care
- Follow up after Hospitalization for Mental Illness
- Cholesterol Management after Acute Cardiovascular Events
- Antidepressant Medication Management
- Chlamydia Screening

Childhood Immunizations

The HEDIS Childhood Immunization measure is a composite that calculates the proportion of children continuously enrolled in the health plan for twelve months prior to their second birthday and who receive the following immunizations by the time period specified and by the child's second birthday:

***4 DTaP (diphtheria-tetanus toxoid-acellular pertussis)**
***3 IPV (injectable poliomyelitis)**
***1 MMR (measles-mumps-rubella)**
***3 HiB (Haemophilus influenza type B meningitis)**
***3 Hep B (Hepatitis B)**
***1 VZV (Varicella or Chicken pox)**

HEDIS also calculates two combination rates. The Combination 1 (Comb 1) rate, which includes all the above immunizations except VZV, is included in this report.

Childhood Immunizations - DTaP

	CHPW	CUP	GHC	Kaiser	Regence
N	77	NR	424	3279	229
Rate	84.42	NR	83.49	84.78	75.55
LCI	75.66	NR	79.84	83.54	69.76
UCI	93.17	NR	87.14	86.03	81.33

State Median	84	State Average	82.1

Childhood Immunizations - IPV

	CHPW	CUP	GHC	Kaiser	Regence
N	77	NR	424	3279	229
Rate	83.12	NR	91.27	90.52	89.52
LCI	74.1	NR	88.47	89.5	85.33
UCI	92.13	NR	94.08	91.53	93.71

State Median	90	State Average	88.6

Childhood Immunizations - MMR

	CHPW	CUP	GHC	Kaiser	Regence
N	77	NR	424	3279	229
Rate	87.01	NR	90.09	92.07	89.52
LCI	78.86	NR	87.13	91.13	85.33
UCI	95.17	NR	93.06	93.01	93.71

State Median	89.8	State Average	89.7

Childhood Immunizations - HiB

	CHPW	CUP	GHC	Kaiser	Regence
N	77	NR	424	3279	229
Rate	85.71	NR	87.03	90.39	86.46
LCI	77.25	NR	83.71	89.37	81.81
UCI	94.18	NR	90.34	91.42	91.11

State Median	86.7	State Average	87.4

Childhood Immunizations - Hepatitis B

	CHPW	CUP	GHC	Kaiser	Regence
N	77	NR	424	3279	229
Rate	84.42	NR	84.43	89.69	79.48
LCI	75.66	NR	80.87	88.64	74.03
UCI	93.17	NR	88	90.75	84.93

State Median	84.4	State Average	84.5

Childhood Immunizations - VZV

	CHPW	CUP	GHC	Kaiser	Regence
N	77	NR	424	3279	229
Rate	70.13	NR	68.16	87.8	69.87
LCI	59.26	NR	63.61	86.67	63.71
UCI	81	NR	72.71	88.94	76.03

State Median	70	State Average	74.0

Childhood Immunizations - Combo 1

	CHPW	CUP	GHC	Kaiser	Regence
N	77	NR	424	3279	229
Rate	68.83	NR	74.06	78.71	62.01
LCI	57.84	NR	69.77	77.3	55.5
UCI	79.83	NR	78.35	80.13	68.51

State Median	71.4	State Average	70.9

Adolescent Immunizations

Adolescent Immunization - MMR

	CHPW	CUP	GHC	Kaiser	Regence
N	NR	NR	427	5271	345
Rate	NR	NR	85.25	90.95	70.72
LCI	NR	NR	81.76	90.17	65.78
UCI	NR	NR	88.73	91.73	75.67

State Media	85.3	State Average	82.3

This measure is the percentage of enrolled adolescents who turned 13 years old during the measurement year, and were continuously enrolled for 12 months immediately prior to their 13th birthday, and had a second dose of MMR, three Hepatitis B and one VZV by their 13th birthday. The measure also calculated two combination measures.

Adolescent Immunization - Hepatitis B

	CHPW	CUP	GHC	Kaiser	Regence
N	NR	NR	427	5271	345
Rate	NR	NR	55.97	74.05	42.32
LCI	NR	NR	51.15	72.85	36.96
UCI	NR	NR	60.8	75.24	47.68

State Median	56	State Average	57.4

Adolescent Immunization - VZV

	CHPW	CUP	GHC	Kaiser	Regence
N	NR	NR	427	5271	345
Rate	NR	NR	65.11	89.05	28.12
LCI	NR	NR	60.47	88.2	23.23
UCI	NR	NR	69.74	89.91	33

State Median	65.1	State Average	60.8

Adolescent Immunization - Combo 1

	CHPW	CUP	GHC	Kaiser	Regence
N	NR	NR	427	5271	345
Rate	NR	NR	55.04	73.08	40.87
LCI	NR	NR	50.2	71.87	35.54
UCI	NR	NR	59.87	74.29	46.2

State Median	55	State Average	56.3

Breast Cancer Screening

***The Healthy People 2010* goal for breast cancer screening is 70 percent. Another goal is to reduce the death rate from breast cancer to 22 per 100,000 females or by 20 percent.**

Breast Cancer Screening

	CHPW	CUP	GHC	Kaiser	Regence
N	4441	327	310	33247	1905
Rate	67.01	74.92	79.68	75.07	77.74
LCI	65.62	70.07	75.04	74.6	75.85
UCI	68.41	79.77	84.32	75.53	79.64

State Median	75.1	State Average	74.9

The Breast Cancer Screening measure is the percentage of women age 50 through 69 who were continuously enrolled during the measurement year and who had at least one mammogram during the measurement year or the prior year.

Cervical Cancer Screening

The *Healthy People 2010* goal is 90 percent for women 18 years and older that have had a Pap test within three years.

A second goal is to decrease the death rate from cancer of the cervix to two per 100,000 population, or a 97 percent rate of Pap tests.

Cervical Cancer Screening

	CHPW	CUP	GHC	Kaiser	Regence
N	411	910	278	411	421
Rate	79.56	74.95	88.13	85.64	85.04
LCI	75.54	72.07	84.15	82.13	81.51
UCI	83.58	77.82	92.11	89.16	88.56

State Median	85	State Average	82.7

This measure is the percentage of women who are age 18 through 64 and had at least one Pap test during the past three years with continuous enrollment in the same health plan during that period.

Beta-Blocker Treatment after a Heart Attack

This measure assesses the percentage of enrolled members 35 years and older who were hospitalized and discharged alive from January 1 to December 24 of the measurement year with a diagnosis of acute myocardial infarction and who received a prescription for beta-blockers upon discharge. The intent of this measure is to assess whether appropriate follow-up care has been rendered to members who suffer a heart attack.

Beta-Blocker After A Heart Attack

	CHPW	CUP	GHC	Kaiser	Regence
N	44	NR	254	282	19
Rate	63.64	NR	92.91	97.52	NA
LCI	48.29	NR	89.56	85.52	NA
UCI	78.99	NR	96.27	99.51	NA

State Median	92.9	State Average	84.7

Comprehensive Diabetic Care

This measure calculates the proportion of members aged 18 to 75 years with diabetes (type 1 and type 2) who were continuously enrolled during the measurement year and who had each of the following (seven separate indicators):

Hemoglobin A1c (HBA1c) tested
HbA1c poorly controlled (>9.5%)
LDL-C screening performed
LDL-C controlled (LDL<130 mg/dL)
LDL-C controlled (LDL<100 mg/dL)
Eye exam (retinal) performed
Kidney disease (nephropathy) monitored

HbA1c Testing

	CHPW	CUP	GHC	Kaiser	Regence
N	411	NR	462	335	429
Rate	87.1	NR	89.18	91.94	81.35
LCI	83.74	NR	86.24	88.88	77.55
UCI	90.47	NR	92.12	95	85.15

State Median	88.1	State Average	87.4

Poor HbA1c Control

	CHPW	CUP	GHC	Kaiser	Regence
N	411	NR	462	335	429
Rate	38.93	NR	28.79	17.01	35.9
LCI	34.09	NR	24.55	12.84	31.24
UCI	43.77	NR	33.02	21.19	40.55

State Median	32.3	State Average	30.2

Eye Exam

	CHPW	CUP	GHC	Kaiser	Regence
N	411	NR	462	335	429
Rate	44.53	NR	60.39	66.87	55.94
LCI	39.6	NR	55.82	61.68	51.13
UCI	49.45	NR	64.96	72.06	60.76

State Median	58.2	State Average	56.9

LDL-C Screening

	CHPW	CUP	GHC	Kaiser	Regence
N	411	NR	462	335	429
Rate	83.94	NR	86.15	82.39	87.18
LCI	80.27	NR	82.89	78.16	83.9
UCI	87.61	NR	89.41	86.62	90.46

State Median	85	State Average	84.9

LDL-C Level <130 mg/dl

	CHPW	CUP	GHC	Kaiser	Regence
N	411	NR	462	335	429
Rate	48.91	NR	61.9	68.06	56.41
LCI	43.95	NR	57.37	62.92	51.6
UCI	53.86	NR	66.44	73.2	61.22

State Median	59.2	State Average	58.8

LDL-C Level <100mg/dl

	CHPW	CUP	GHC	Kaiser	Regence
N	411	NR	462	335	429
Rate	25.55	NR	39.39	38.81	30.77
LCI	21.21	NR	34.83	33.44	26.29
UCI	29.89	NR	43.96	44.17	35.25

State Median	34.8	State Average	33.6

Monitoring for Diabetic Nephropathy

	CHPW	CUP	GHC	Kaiser	Regence
N	411	NR	462	335	429
Rate	54.26	NR	55.63	52.24	47.55
LCI	49.32	NR	50.99	46.74	42.71
UCI	59.2	NR	60.27	57.74	52.39

State Median	53.3	State Average	52.4

Follow Up after Hospitalization for Mental Illness

This measure is the percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental health disorders, who were continuously enrolled for 30 days after discharge, and who were seen on an ambulatory basis or were in day/night treatment with a mental health provider.

30-day follow-up

	CHPW	CUP	GHC	Kaiser	Regence
N	NR	NR	418	796	36
Rate	NR	NR	81.34	75.25	63.89
LCI	NR	NR	77.49	72.19	46.81
UCI	NR	NR	85.19	78.31	80.97

State Median	75.3	State Average	73.5

Cholesterol Management after Acute Cardiovascular Events

The percentage of members 18 to75 years of age on December 31st of the measurement year, who were discharged alive in the year prior to the measurement year for acute myocardial infarction, coronary artery bypass graft, or percutaneous transluminal coronary angioplasty, and had evidence of LDL-C screening and an LDL-C of less than 130 mg/dL.

LDL-C Screening

	CHPW	CUP	GHC	Kaiser	Regence
N	NR	NR	427	627	51
Rate	NR	NR	74.71	82.14	86.27
LCI	NR	NR	70.47	79.06	75.85
UCI	NR	NR	78.95	85.22	96.7

State Median	82.1	State Average	81.0

LDL-C Level <130 mg/dl

	CHPW	CUP	GHC	Kaiser	Regence
N	NR	NR	427	624	51
Rate	NR	NR	64.64	76.24	58.82
LCI	NR	NR	59.99	72.82	44.34
UCI	NR	NR	69.29	79.65	73.31

State Median	64.6	State Average	66.6

LDL-C Level <100 mg/dl

	CHPW	CUP	GHC	Kaiser	Regence
N	NR	NR	427	627	51
Rate	NR	NR	45.67	60.13	45.1
LCI	NR	NR	40.83	56.22	30.46
UCI	NR	NR	50.51	64.04	59.74

State Median	45.7	State Average	50.3

Antidepressant Medication Management

Optimal Practitioner

	CHPW	CUP	GHC	Kaiser	Regence
N	453	60	4759	4948	146
Rate	9.05	13.33	12.63	12.61	30.14
LCI	6.3	3.9	11.67	11.68	22.35
UCI	11.8	22.77	13.58	13.55	37.92

State Median	12.6	State Average	15.6

This measure assesses three components of successful pharmacological management of depression: optimal practitioner contacts for medication management, effective acute phase treatment, and effective continuation phase treatment. The specifications are lengthy and can be found in detail in the HEDIS Technical Specifications manual and on the NCQA website.

Acute Phase Treatment

	CHPW	CUP	GHC	Kaiser	Regence
N	453	60	4759	4948	146
Rate	39.29	61.67	69.26	70.57	67.81
LCI	34.69	48.53	67.94	69.29	59.89
UCI	43.9	74.8	70.58	71.85	75.73

State Median	67.8	State Average	61.7

Continuation Phase Treatment

	CHPW	CUP	GHC	Kaiser	Regence
N	453	60	4759	4948	146
Rate	24.06	36.67	51.86	53.62	46.58
LCI	20.02	23.64	50.43	52.22	38.14
UCI	28.11	49.69	53.29	55.02	55.01

State Median	46.6	State Average	42.6

Chlamydia Screening

The percentage of women age 16 to 26 who were identified as sexually active, were continuously enrolled during the measurement year, and who had at least one test for Chlamydia during the measurement year.

Chlamydia Screening - Ages 16-20

	CHPW	CUP	GHC	Kaiser	Regence
N	475	NR	4929	2650	263
Rate	33.26	NR	42.4	49.11	30.8
LCI	28.92	NR	41.01	47.77	25.03
UCI	37.61	NR	43.79	50.45	36.57

State Median	37.8	State Average	38.9

Chlamydia Screening - Ages 21-25

	CHPW	CUP	GHC	Kaiser	Regence
N	1483	NR	5171	3233	290
Rate	33.31	NR	42.1	50.97	35.86
LCI	30.88	NR	40.74	49.73	30.17
UCI	35.74	NR	43.46	52.21	41.55

State Median	39	State Average	40.6

Chlamydia Screening - Total

	CHPW	CUP	GHC	Kaiser	Regence
N	1958	NR	254	5883	553
Rate	33.3	NR	92.91	50.12	33.45
LCI	31.19	NR	89.56	49.21	29.43
UCI	35.41	NR	96.27	51.02	37.48

State Median	37.9	State Average	52.4

GLOSSARY

Administrative method: The administrative method uses data derived solely from health plan information systems, such as claims, eligibility, enrollment, and encounter data, and calculates a rate using all of the eligible members who satisfy the denominator criteria specified for a measure. The numerator is derived from all members in the denominator who received the service(s) shown in paid claims.

The administrative method is cost effective, but may yield lower rates due to errors of omission, data entry, idiosyncratic coding, late submission, or capitated compensation.

Audit designations: R (report) means the health plan followed the specifications and produced a reportable rate; NR (not report) means the health plan did not calculate the rate, the rate was materially biased, or the health plan chose not to report the rate.

Confidence Interval: When a sample is collected instead of the entire eligible population, the resulting rate is a statistical estimate. The precision of that estimate is the confidence interval or margin of error, and refers to the likelihood that a score falls within a given range around an estimate.

Hybrid method: The hybrid method extracts a random systematic sample from all eligible members in the administrative data, and reviews medical records of members in the sample whose claims data do not indicate the service was received. These members augment the result when evidence is found that the service was provided.

The hybrid method generally produces a higher, more accurate rate. Medical record review can find services provided that are bundled with a single code in a claim, but records can be incomplete or illegible, and the process is labor intensive and expensive.

Immunization: Immunization is a process by which a person is rendered resistant to a specific disease.

Rotation: NCQA allows a rotation strategy, which allows a rate to count for two years, to reduce health plan reporting burden and allow time to demonstrate improvement between measurement periods. A valid result from the prior year is required before a measure may be rotated.

Appendix

2003 MANAGED CARE PLANS			
Health Plan Name	**Abbreviation**	**Population**	**Service Counties**
Community Health Plan of Washington	**CHPW**	Medicaid, commercial	Adams, Benton, Chelan, Clallam, Clark, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Orielle, Pierce, Skamania, Snohomish, Spokane, Skagit, Stevens, Thurston, Walla Walla, Whitman, Whatcom, Yakima
Columbia United Providers	**CUP**	Medicaid, commercial	Clark, Cowlitz, Clark, Klickitat, Pacific, Skamania, Wahkiakum
Group Health Cooperative	**GHC**	Medicaid, commercial	Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Franklin, Garfield, Grays Harbor, Island, Jefferson, King, Kitsap, Kititas, Lewis, Lincoln, Mason, Okanogan, Pend Oreille, Pierce, San Yuan, Skagit, Stevens, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, Yakima
Kaiser Foundation Health Plan of the Northwest	**Kaiser (KHP)**	BH Plus, commercial	Clark, Cowlitz , King, Klickitat, Lewis, Mason, Pacific, Pierce, Skagit, Skamania, Thurston, Wahkiakum, Whatcom, Yakima
Molina Healthcare of Washington Inc.	**Molina (MHC)**	Medicaid Basic Health	Adams, Benton, Chelan, Clallam, Columbia, Cowlitz, Douglas, Garfield, Grant, Grays Harbor, Franklin, Island, King, Kitsap, Lincoln, Lewis, Mason, Pacific, Pend Oreille, Okanogan, Pierce, San Juan, Spokane, Skagit, Snohomish, Thurston, Walla Walla, Whatcom, Whitman, Yakima
PacifiCare	**PAC**	Commercial	Benton, Clark, Cowlitz, Franklin, Grays Harbor, Island, King, Kitsap, Kittitas, Lewis, Mason, Okanogan, Pacific, San Juan, Skagit, Pierce, Snohomish, Thurston, Walla Walla, Whatcom, Yakima
Premera Blue Cross	**PBC**	Medicaid, commercial	Adams, Asotin, Benton, Chelan, Clark, Columbia, Cowlitz, Douglas, Franklin, Ferry, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kititas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, Yakima
Regence BlueShield and RegenceCare	**RBS**	Medicaid, commercial	Adams, Benton, Chelan, Clallam, Clark, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Lewis, Mason, Pacific, Pend Oreille, Skagit, Skamania, Spokane, Stevens, Thurston, Wahkiakum, Pierce, San Juan, Snohomish, Whatcom, Yakima